

**GROUP HEALTH
BENEFITS**

for employees of

**READING SCHOOL DISTRICT
PPO Plan II**

Effective January 1, 2006

Loomis PPO Plan IIIN Option

INTRODUCTION

This Summary Plan Description describes the Medical, Prescription drug, Dental & Vision benefits available to employees of The Reading School District Health Care Plan. The benefits described in this document are effective January 1, 2006. This document summarizes the Plan rights and benefits for covered employees and their dependents. By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So know your plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

When you become a Covered Person, you will have available to you a listing of the participating Hospitals and physicians of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on the front of your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company - website www.loomisco.com contains links to many online provider directories under the *PPO Directory* option. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

The participating Hospitals and physicians of the network have agreed to extend a discount to those employees and covered dependents that utilize their facilities. When your claims for Hospital services are processed, you will see the amount of the discount on the Explanation of Benefits (EOB). This, of course, helps reduce your liability for the cost of the services.

One of the advantages of the PPO network to you, as a consumer of medical care, deals with the determination of what charges are acceptable for benefit payment. As defined later in this booklet, *covered expenses* will be considered only up to the usual, customary and reasonable charge for the geographic area in which the service is rendered. This means that if a network physician bills an amount in excess of the usual, customary and reasonable amount, you cannot be billed for the excess charge. This provision of the Plan can be meaningful and offers additional financial benefits when PPO providers are used for medical care.

IMPORTANT HIGHLIGHTS

(1) **MANDATORY HOSPITAL PRE-NOTIFICATION**

YOU MUST OBTAIN PRE-NOTIFICATION FOR INPATIENT HOSPITAL ADMISSIONS, SKILLED NURSING FACILITY ADMISSIONS, AND HOME HEALTH CARE. Refer to the Utilization Review Section of this Summary Plan Description.

(2) **YOU MUST NOTIFY THE HUMAN RESOURCES DEPARTMENT WHEN ONE OF THE FOLLOWING EVENTS OCCURS.**

- Birth of child. *(Within 30 days).*
- Your covered child turns 19. *(Within 60 days)*
- Your covered full-time student graduates, ends school or turns 25. *(Within 60 days). Verification of their educational status required each semester.*
- Divorce. *(Within 60 days).*
- Marriage. *(Within 30 days).*
- Adoption of child. *(Within 30 days).*

Failure to notify the Human Resources Department of these events could result in loss of eligibility and claims being denied.

(3) **YOU MUST BE SURE NETWORK PROVIDERS HAVE CURRENT BILLING INSTRUCTIONS PROVIDED ON YOUR IDENTIFICATION CARD. FAILURE TO SUBMIT CLAIMS PROPERLY WILL RESULT IN DELAYED CLAIMS PROCESSING.**

(4) **BILLS SHOULD BE SUBMITTED FOR PAYMENT IN A TIMELY BASIS.**

Claims filed more than 18 months after the date of service will not be eligible for payment.

A Summary Plan Description (SPD) is intended to summarize the features of your Health Care Plan in clear, understandable and informal language. The terms under which the Plan administers benefits are contained in this booklet.

TABLE OF CONTENTS

	<u>Page</u>
SCHEDULE OF BENEFITS	5
UTILIZATION REVIEW	8
HOW TO FILE A CLAIM.....	10
DEFINITIONS	15
ELIGIBILITY PROVISIONS.....	21
TERMINATION OF COVERAGE	26
COMPREHENSIVE MEDICAL EXPENSE BENEFIT	27
MEDICAL EXCLUSIONS AND LIMITATIONS	38
DENTAL EXPENSE BENEFIT	43
DENTAL EXCLUSIONS.....	49
VISION CARE EXPENSE BENEFIT	52
VISION EXCLUSIONS.....	53
PRESCRIPTION DRUG EXPENSE BENEFIT	54
PRESCRIPTION EXCLUSIONS	54
CONTINUATION OF COVERAGE.....	56
FAMILY SECURITY BENEFIT	59
MEDICAL CARE CONVERSION PRIVILEGE	59
FAMILY MEDICAL LEAVE ACT/MILITARY LEAVE OF ABSENCE.....	60
COORDINATION OF BENEFITS.....	62
GENERAL PROVISIONS AND INFORMATION	66
RIGHTS AND PROTECTIONS	67
NOTICE OF PRIVACY PRACTICES.....	69
FACTS ABOUT THE PLAN.....	73

This booklet is not a contract. It explains in non-technical language the essential features of your Employee Benefit Program.

You should contact your employer if you have any questions concerning your coverage.

LE 09/08/06

SCHEDULE OF BENEFITS

COMPREHENSIVE MEDICAL EXPENSE BENEFIT		
Maximum Benefits, per Covered Person:		
All Benefits Combined, per Lifetime		\$2,000,000
	BHP	Out-of-Network
First Dollar Deductible, per Calendar Year:		
Per Individual	\$500	\$1,000
Per Family	\$1,000	\$2,000
Benefit Percentage:		
Medical Plan Pays	80%	60%
Covered Person Pays	20%	40%
Out-of-Pocket Maximum per Calendar Year, Including Deductible*:		
Per Individual	\$1,500	\$3,000
Per Family	\$3,000	\$6,000
<i>*Mental Health & Substance Abuse Treatment expenses do not accrue to the out-of-pocket maximum.</i>		
FACILITY CHARGES: (Subject to Deductible and Co-Payment)		
Pre-Admission Review	Required	
Daily Room and Board Benefit	Semi-Private	
	BHP Plan Pays * Allowable Amount (After Deductible)	Out-of-Network Plan Pays *UCR (After Deductible)
Medically Necessary Special Care Units	80%	60%
Facility Ancillary Expenses	80%	60%
Skilled Nursing Facility (Up to 180 Days per Consecutive 12 Month Period)	80%	60%
Home Health Care	80%	60%
Hospice (Up to \$2,500 per Lifetime)	80%	60%
Birthing Facility	80%	60%
Out-patient Surgery	80%	60%
PROFESSIONAL CHARGES: (Subject to Deductible and Co-payment)		
Surgery	80%	60%
Anesthesia	80%	60%
In-patient Physician Visits	80%	60%
Second Surgical Opinion	80%	60%
In-patient Consultation	80%	60%

	BHP Plan Pays * Allowable Amount (After Deductible)	Out-of-Network Plan Pays *UCR (After Deductible)
OTHER FACILITY AND/OR PROFESSIONAL CHARGES: (Subject to Deductible and Co-Payment)		
Pre-Admission Testing	80%	60%
Diagnostic X-ray and Laboratory	80%	60%
Emergency Services	80%	60%
Therapy <i>Includes Physical, Occupational, Speech, Chemotherapy, etc.</i> (Up to 30 visits per Calendar Year)	80%	60%
Psychiatric Care		
• Inpatient Up to 30 Days per Calendar Year	80%	60%
Partial Hospitalization (2 for 1 against Inpatient)	80%	60%
• Outpatient Up to 60 Visits per Calendar Year	80%	60%
Chemical Dependency Care		
• Inpatient Up to 150 days per Calendar Year.	80%	60%
• Outpatient	80%	60%
Acupuncture (Up to 30 visits per Calendar Year)	80%	60%
Physician Office Visits	80%	60%
Allergy Injections	80%	60%
Pregnancy <i>No coverage for a dependent daughter age 19 and over</i>	80%	60%
Preventive Services (1 per Calendar Year)	80% up to \$1,000 per Calendar Year <i>Includes Well Baby Visits</i>	Not Covered
Routine Immunizations	80%	Not Covered
Annual Gynecological Exam	80%	Not Covered
Mammograms (When provided at periodic interval as medically necessary)	80%	Not Covered

Chiropractic Care (Up to 30 days per Calendar Year)	80%	Not Covered
Durable Medical Equipment (Up to \$5,000 per Calendar Year)	80%	60%
All Other Covered Expenses	80%	60%
DENTAL EXPENSE BENEFIT		
Deductible Amount: Classes I, II and III Combined Class IV	None \$50 per Calendar Year	
Covered Expenses and Co-Payment: Class I Preventive and Diagnostic Class II Basic Restorative Class III Major Restorative Class IV Orthodontic	100% 100% 50% 50%	
Maximum Benefits: Classes I, II and III Combined Class IV	\$1,000 per Calendar Year \$750 per Lifetime	
VISION CARE EXPENSE BENEFIT		
Examination	100% of Reasonable and Customary	
Lenses (per pair): Single Vision Bi-Focal Tri-Focal Aphakic	\$24 \$32 \$46 \$110	
Frames	\$24	
Contact Lenses, per pair: Medically Necessary Hard Lenses Soft Lenses If Otherwise Prescribed	\$100 \$150 \$50	
PRESCRIPTION DRUG PLAN		
Prescription Drugs purchased at a pharmacy: Generic, per prescription or refill Preferred Brand Name, per prescription or refill All Others, per prescription or refill	\$10 \$25 \$40	
Mail Order Prescription Drugs (Mandatory for Maintenance Drugs) <i>90 Day Supply</i> Generic, per prescription or refill Preferred Brand, per prescription or refill All Others, per prescription or refill	\$10 \$50 \$80	

UTILIZATION REVIEW

This program monitors your proposed inpatient admission and helps assure that your treatment is medically necessary and appropriate. You must use this program to obtain maximum benefits in the event of an inpatient admission (hospital or skilled nursing facility) or when beginning a program of home health care.

NON-EMERGENCY ADMISSIONS OR HOME HEALTH CARE

If your physician decides you or your dependent needs to be admitted or recommends home health care, show him or his staff member your benefits ID card.

Call MEDICUS at the number indicated on your identification card. Ask for the Utilization Review nurse and be prepared to give the following information:

1. Employee's name, address, phone number and Social Security number.
2. Employer's name.
3. Patient's name, date of birth, address and phone number.
4. Admitting physician's name and phone number.
5. Name of facility, home health care agency or hospice.
6. Date of admission.
7. Condition for which patient is being admitted.

EMERGENCY ADMISSIONS

Within 48 hours following the admission, the same notification as listed above must be given.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NMHPA)

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

TELEPHONE NUMBERS FOR MEDICUS

Local
Toll-Free

610-372-8417
1-800-647-2500

Monday - Friday 8 A.M. to 5:30 P.M.

IF YOU DO NOT NOTIFY MEDICUS

If you do not use this pre-admission review program, reimbursement of covered facility charges will be reduced by \$300 from what they would have been had the program been used. For example, if you incur \$1,000 of covered hospital charges, only \$700 will be considered.

NOTE: The health care provider is not responsible for making the required call. Notification of your admission by the facility may not fulfill your obligation to make the call.

SECOND SURGICAL OPINION REQUIREMENT

Second surgical opinions may be required by the Utilization Review nurse for certain inpatient surgical procedures. If so, expenses incurred for the second opinion will be covered at 100% under the Comprehensive Medical Expense Benefit. If you do not obtain a second surgical opinion when it is required, the benefits for charges by the surgeon will be reduced by 50%.

Second surgical opinions other than those required by the Utilization Review nurse are subject to the deductible and co-payment provisions of the Plan.

GASTRIC BYPASS SURGERY

If your physician recommends that you or a dependent would benefit from Gastric Bypass Surgery, a call must be placed to MEDICUS. MEDICUS must deem the surgery to be medically necessary and must be performed by a provider according to the terms of your contract. If MEDICUS does not deem the surgery to be medically necessary or is performed by a provider not eligible under the terms of your contract, no benefits will be available for the surgery and any related expenses.

HOW TO FILE A CLAIM

MEDICAL SERVICES

Berkshire Health Plan Providers

You do not need to submit a bill. The physician or hospital will send the bill directly to Berkshire Health Plan for review and submission to The Loomis Company.

If a Health Claim Form is required in order to properly process your claim, The Loomis Company will advise you. Health Claim Forms are available in the individual school building office or the district personnel office.

NOTE: Payments by the Plan for covered expenses will be made directly to Berkshire Health Plan participating facilities and professional providers unless a receipt or other proof of payment is submitted along with the expense.

All Other Healthcare Providers

Separate all bills for each family member. A separate claim must be filed for each covered person.

Your claims should be submitted with a Health Claim Form to The Loomis Company as soon as possible. Expenses filed more than 18 months after the date of service will NOT be honored.

The following are not acceptable as proof of claim: cash register receipts, cancelled checks, money order receipts and personal listings. Please keep a record of items you submit for payment.

Professional Bills - (Physician, Lab, Etc.)

Have your professional provider complete the reverse side of our Health Claim Form. You should complete the front side of the form. Be sure to sign and date the form in the appropriate spaces, and then mail it to the address listed.

If your professional provider does not complete the reverse side of the claim form, obtain an itemized bill or super-bill that shows the following:

1. Patient's name.
2. Diagnosis.
3. Date of each service.
4. Description of each service performed.
5. Name and address of professional provider.

Attach the itemized bill or super-bill to a claim form on which you have completed the front side. Sign and date the form in the appropriate spaces, then mail it to the address listed.

Facility Bills - (Hospital, Skilled Nursing Facility, Etc.)

The facility should submit charges directly to the address listed on the front of your Group ID Card, using its standard health insurance claim form. Payment will be made directly to the facility and an explanation of benefits paid will be sent to you. If the Plan does not pay the facility bill in full, it is your responsibility to remit the unpaid balance to the facility.

If the facility does not submit charges directly, obtain an itemized bill for all services rendered. Attach the itemized bill to our Health Claim Form on which you have completed the front side. Sign and date the form in the appropriate spaces, then mail it to the address listed.

Other Health Care Expenses

Private Duty Nurses - Secure an itemized bill that shows the following:

1. Name of patient.
2. Individual dates of service.
3. Shift worked on each date of service.
4. Nurse's name and registration number.
5. Name of physician who ordered nursing services.
6. Copy of physician's diagnosis and written order for the services.

Oxygen, Durable Medical Equipment, Prosthetics and Orthotics - Secure an itemized bill that shows the following:

1. Name of patient.
2. Dates of services.
3. Rental and purchase price of equipment.
4. Accurate description of each item.
5. Name and address of supplier.
6. Professional provider's written order for the equipment. (The order should include an estimate of the period of need.)

DENTAL SERVICES

A Dental Claim Form, available from the personnel office, must be completed by you and your dentist.

1. If a course of treatment can reasonably be expected to be less than \$150, you should:

- a. Complete Part I on the form.
 - b. Have your dentist complete Part II (or attach a super-bill to the form) after treatment is completed.
 - c. Mail the claim form, and X-rays if applicable, to the address listed on the form.
2. If a course of treatment can reasonably be expected to equal or exceed \$150, a Pre-Determination of Benefits should be obtained. You should:
- a. Complete Part I on the form.
 - b. Have the dentist complete Part II on the form, indicating the procedures to be performed and the proposed fees.
 - c. The dentist should submit the completed form, with X-rays, to your dental carrier (X-rays must be submitted with the claim form whenever the charge for the treatment plan equals or exceeds \$150).
 - d. Upon review of the information submitted, The covered person and the dentist will be notified of the benefit payable.
 - e. After the work is completed, the dentist should indicate on the form the specific services performed, dates of services, and the charges. The dentist should send the completed form to the address listed on the form.

VISION SERVICES

A Medical Claim Form, available from the personnel office, must be completed by you and the provider of services.

1. Complete Part A on the form.
2. After treatment is completed, attach an itemized receipt.
3. Send the completed form to the address listed.

PRESCRIPTION DRUGS PURCHASED AT A PHARMACY

When you have a prescription to be filled, you should:

1. Present the prescription drug card and the prescription to the participating pharmacist.
2. Complete and sign the insured's portion of the voucher.

3. Pay the co-pay amount and receive the medication.

Everything else is taken care of between the member pharmacy and your Rx Drug Manager.

MAIL ORDER PRESCRIPTION DRUGS

Your prescription maintenance drugs may be purchased through the mail service pharmacy. Maintenance drugs are medications you are taking on an ongoing basis. These drugs are for conditions such as heart disease, high blood pressure, diabetes, ulcers, arthritis, etc. Mail order prescriptions may be filled for up to a 90-day supply plus 3 additional refills as long as the prescription is for a 90 day supply.

HOW TO APPEAL A CLAIM DENIAL

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a physician or other health professional, you or your representative will be referred to the physician for the information before the Plan will provide the requested documents directly to you or your representative. Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action under Section 502(a) of ERISA.

ADVERSE BENEFIT DETERMINATION

Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

COMPLIANCE WITH REGULATIONS

It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

AUTHORIZED REPRESENTATIVE

A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

OTHER IMPORTANT CLAIMS INFORMATION

If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding except as otherwise provided by ERISA.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

MEDICAL PRIVACY

Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

FACILITY OF PAYMENT

In the event of your death or mental incompetence at a time when benefits remain unpaid, benefits will be paid to the person or institution with which the covered charges were incurred if the charges have not otherwise been paid.

NOTICE OF CLAIM

All bills should be submitted as soon as possible and will not be honored 18 months beyond the date of service.

DEFINITIONS

The following are some of the definitions of terms used in this booklet:

COVERED PERSON

A person who meets the definition of an Employee and such Employee's Dependents who have satisfied the eligibility requirements.

CUSTODIAL CARE

Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a sickness, disease, injury or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services are custodial care without regard to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

DEPENDENT

An eligible dependent is:

- a. The lawful spouse of the employee under a legally existing marriage as recognized by the State of Pennsylvania;
- b. Your unmarried child who is under 19 years of age; and
- c. Your unmarried child who is 19 years of age and under 25 years of age if enrolled in a full-time curriculum at an accredited secondary school, college, university or institution of higher learning, and who is primarily dependent upon you for maintenance and support and is not regularly employed on a full-time basis exclusive of scheduled vacation periods. Discontinuing status as a full-time student will result in termination of coverage at the end of the month in which enrollment was discontinued.

Dependent children may include any natural child, stepchild, or legally adopted child, or one for whom legal adoption proceedings have been initiated, or foster child, or any child related to you by blood or marriage, who depends upon you for maintenance and support.

A child who, by reason of a physical or mental handicap, is incapable of self support upon attaining the limiting age in the Plan will be considered a dependent, while remaining incapacitated and unmarried, subject to your own coverage continuing in effect. To cover a child under this provision, proof of incapacity must be received by the

Plan Supervisor within 31 days after coverage would otherwise terminate. Additional proof may be required from time to time.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is medical equipment which 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is generally not useful to a person in the absence of an illness or injury; and 4) is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

EMPLOYEE

A person directly employed in the regular business of and compensated for services by the employer and who is regularly scheduled to work on a full-time basis.

EMPLOYER

The employer is Reading School District, 800 Washington Street, Reading, Pennsylvania 19601.

EXPERIMENTAL OR INVESTIGATIVE

The use of any treatment, procedure, facility, equipment, drug or drug usage, device or supply not accepted as standard treatment of the condition being treated by the general medical or dental community, or any such items requiring Federal or other governmental agency approval not granted at the time services were rendered.

FACILITY PROVIDER

An institution or other entity licensed where required and performing services within the scope of such license. The covered facility providers are limited to:

Ambulatory Surgical Facility	Hospice
Birthing Facility	Hospital
Chemical Dependency	Out-patient Psychiatric Facility
Detoxification and/or Rehabilitation Facility	Psychiatric Hospital
Day/Night Psychiatric Facility	Rehabilitation Hospital
Freestanding Dialysis Facility	Skilled Nursing Facility
Home Health Care Agency	

FULL-TIME; FULL-TIME BASIS

An employee who is regularly scheduled to work not less than 25 hours per week.

HOSPITAL

Any institution for care of the sick or injured which is licensed to operate as such, and which has nurses on duty 24 hours a day, a physician on call at all times, and facilities for diagnosis of sickness and for major surgery. A hospital must meet certain other requirements which are more fully described in the Plan Document.

The term hospital, when used in connection with inpatient confinement for mental illness or chemical dependency, will be deemed to include an institution which is licensed as a mental hospital or chemical dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

INJURY

Accidental, bodily injury which does not arise out of or in the course of employment. Injury shall not include any intentionally self-inflicted injury.

INPATIENT

A person who is treated as a registered bed patient in a hospital or other covered facility and for whom a room and board charge is made.

LEAVE OF ABSENCE

A period of time during which you, by your own request, do not work for the employer but which is of stated duration and after which time you are expected to return to full-time, active work. Leaves of absence are granted in accordance with your employer's standard personnel practices and policies.

MEDICAL CARE

Professional services rendered by a professional provider for the treatment of a condition not otherwise payable as surgery, maternity services, therapy services, or mental illness or chemical dependency care.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Treatment, services or supplies which are:

- a. Appropriate for the symptoms and provided for the diagnosis or treatment of the covered person's condition, sickness, disease, injury or preventive dental care; and
- b. Provided for the diagnosis, or the direct care and treatment of the covered person's condition, sickness, disease, injury or preventive dental care; and

- c. In accordance with current standards of medical or dental practice; and
- c. Not primarily for the convenience of the covered person or the covered person's facility or professional provider; and
- d. The most appropriate supply or level of service that can safely be provided to the covered person. When applied to an inpatient admission, this further means that the covered person requires acute care as a bed patient due to the nature of the services rendered or the covered person's condition, and the covered person cannot receive safe or adequate care as an outpatient.

Concurrent and/or periodic review of the medical necessity of treatment will be performed with respect to all inpatient care, regardless of the type facility, and home health care.

MENTAL (OR NERVOUS) ILLNESS

An emotional or mental disorder characterized by an abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominating feature.

NECESSARY SERVICES AND SUPPLIES

Shall include any charges, other than charges for room and board, made by a covered facility provider on its own behalf for necessary medical services and supplies actually administered during confinement at such institution. Necessary services and supplies will also include admission fees where applicable, charges of a radiologist, pathologist and other professional components while confined, whether or not such services are charged by the hospital, but will not include any charges for private duty nursing services, or dental, medical or surgical fees whether billed by a facility of professional provider.

NON-PARTICIPATING PHARMACY

Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs which does not come within the definition of participating pharmacy.

NURSE

A licensed person holding the degree Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), who is practicing within the scope of the license.

OUTPATIENT

Any Covered Person who receives services and supplies while not an inpatient.

PARTICIPATING PHARMACY

Any pharmacy licensed to dispense prescription drugs which is included in the network maintained by your Rx Drug Manager.

PHYSICIAN

A person who is a legally qualified and licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Podiatry (D.P.M.) or Doctor of Ophthalmology or Optometry (O.D. or M.D.).

PRE-EXISTING CONDITION

Any injury or sickness for which you either received medical treatment, services or advice or took prescribed drugs or medicines during the 90-day period preceding your first day of coverage or the most recent re-employment date. The same 90-day period will apply to your dependent. For a dependent acquired at a later time, it will be the 90-day period prior to the dependent's effective date of coverage.

PREFERRED PROVIDER ORGANIZATION

Reading School District may choose to participate in a Preferred Provider Organization or PPO that offers discounts to you and your dependents if you choose to participate. Participation in a PPO encourages quality medical care and controls Plan costs.

For further information about PPO'S, please contact your Employer's personnel office.

PROFESSIONAL PROVIDER

Provider shall include an Audiologist, Physician Assistant (P.A.C.), Nurse Practitioner, Certified Addiction Counselor (C.A.C.), Certified Nurse Anesthetist, Certified Drug Professional (C.D.P.), Certified Nurse Practitioner (C.N.S.), Certified Midwife Nurse (C.M.N.), Licensed Professional Physical Therapist, Midwife, Licensed Social Worker (L.S.W.), Occupational Therapist (O.T.), Speech Language Pathologist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Professional Counselor, Licensed MSW, and an Acupuncturist. Coverage will not be provided if such a provider is the employee, the employee's spouse, child, brother, sister, or parent of the employee.

QUALIFIED PRESCRIBER

A physician, dentist or other health care practitioner who may, in the legal scope of the license, prescribe drugs or medicines.

REASONABLE AND CUSTOMARY

Reasonable and Customary means the usual charge made by the physician, hospital or other medical professional providing the service or medical supplies. However, this is limited also in that the charge shall not be in excess of the normal charges for similar services or supplies within the local area in which your service is rendered. Generally, the local area is defined as a county or such additional area as is necessary to obtain a reasonable cross section of other medical professionals or institutions providing such services or supplies.

Physician charges under the Comprehensive Medical Expense Benefit will be paid at the usual Plan co-payment when they equal the Reasonable and Customary level plus up to an additional \$15. Any amount over the Reasonable and Customary level plus \$15 is not eligible under the Plan.

Dentist charges under the Dental Expense Benefit will be paid at the usual Plan co-payment when they equal the Reasonable and Customary level plus up to an additional \$25. Any amount over the Reasonable and Customary level plus \$25 is not eligible under the Plan.

SICKNESS

Any pregnancy or illness, other than an injury, not covered by Workers' Compensation or any occupational disease act.

TEMPORARY LAYOFF

A period of time during which you, at your employer's request, do not work for your employer, but which is of a stated or limited duration and after which time you are expected to return to full-time, active work. Temporary layoffs will otherwise be in accordance with your employer's standard personnel practices and policies.

TOTAL DISABILITY; TOTALLY DISABLED; DISABILITY

When you are unable to perform your regular or customary occupation or employment solely because of an injury or sickness, or your dependent's inability to perform the normal activities of a person of like age and sex who is in good health.

ELIGIBILITY PROVISIONS

INITIAL ENROLLMENT PERIOD

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Reading School District within 30 days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them under a special enrollment period.

Failure to enroll by the deadline noted above may result in your and/or your dependents' inability to secure coverage under this Plan except as specified in the special enrollment and late enrollment provisions below.

TWO SPOUSE RULE

If employees are married to each other the spouse whose birthday falls first during the year shall be entitled to family coverage and the other spouse shall be considered an in-family dependent; however, this in-family dependent shall be eligible for the twenty-one (21) free office visits. The two spouse rule does not apply to dental and vision benefits.

SPECIAL ENROLLMENT PERIODS

Those individuals who do not enroll in the Plan at the first opportunity and subsequently lose coverage may be able to enroll in the Plan in compliance with the Health Insurance Portability and Accountability Act of 1996. The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

An individual must be allowed to enroll under the Plan if:

- The employee or dependent incurs a claim that would meet or exceed a lifetime limit on all benefits;
- The employee or dependent had been covered under another group health plan or had an individual health policy at the time coverage was initially offered;
- If required by the Plan Administrator, the employee stated at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan;

- The individual lost coverage as a result of a certain event, such as the loss of eligibility for coverage, loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees), expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or employer contributions towards such coverage were terminated;
- A new model notice of special enrollment rights is provided. This notice must be provided on or before the time an employee is initially offered the opportunity to enroll in a group health plan; or
- The employee requested such enrollment within 31 days of termination of the coverage.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

DEPENDENT SPECIAL ENROLLMENT PERIOD

Since the Plan provides dependent coverage, when a person becomes a dependent through marriage, birth or adoption, the Plan must provide a dependent special enrollment period of not less than 31 days. If an individual seeks to enroll a dependent during the first 31 days, coverage must become effective:

- In the case of marriage, no later than the first day of the first month beginning after the date the request was completed.
- In the case of a dependent's birth, the date of such birth.
- In the case of adoption or placement for adoption, the date of such adoption, or placement of adoption.

NEWBORN ENROLLMENT

A newborn child will automatically be covered for the first 31 days immediately following birth. Such coverage will end 32 days after the birth of the child. If you agree to contribute any required amounts as defined by the Plan and complete an enrollment form within the initial 31-day period, coverage on the child may continue.

If for any reason you do not enroll within 31 days after the termination of coverage or within 31 days after marriage, birth, adoption or placement for adoption, you and your dependents will not be eligible for coverage.

ELECTION CHANGES

In general, you will not be able to revoke or change your election for a plan year. Federal law generally prohibits you from making any changes to your election that affect the dollar amount or taxability of your payroll contributions, except during open enrollment. However, such changes are permitted if they are needed because of a “change of status” and the election is consistent with the change in status. It is possible to experience a “change in status” event, but not have the change affect your eligibility to participate in this Plan or another plan. In this case you cannot make a change in your election.

CONSISTENCY RULE - Requires that the change in status result in the Employee, Spouse or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Spouse’s or Dependent’s employer, and that the election change correspond with that gain or loss of coverage.

To revoke your election and make a new election, Human Resources must receive the appropriate forms within 31 days of the date of your change of status. If your change in status occurs with less than 31 days remaining in the plan year, the 30-day requirement will extend into the New Year (however, if you wait until the new year to make your adjustments, it can only affect the benefits you have in the new year). **No change in your election will be permitted after this 31-day period.** You may change your elections once a year during the annual open enrollment period or within 31 days of the following events. These events are referred to as a “Change in Status”:

- LEGAL MARITAL STATUS - Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- NUMBER OF DEPENDENTS - Events that change your number of dependents including birth, adoption, placement for adoption or death of dependent. (Note: Gaining or losing a dependent who is not a tax dependent-such as a parent, domestic parent, or child will not be considered an allowable event for an election change.)
- EMPLOYMENT STATUS/WORK SCHEDULE - Events that change your employment status or the employment status of your spouse or dependents that effect your eligibility for benefits including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.
- DEPENDENT SATISFIES OR CEASES TO SATISFY THE REQUIREMENTS FOR UNMARRIED DEPENDENTS - Events that cause your dependents to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any other similar circumstances.

- RESIDENCE OR WORKSITE - Events that change your place of residence, the place of residence of your spouse or dependent that effect eligibility for benefits under the Plan.

You may also change your elections within 31 days of the following events:

- COST CHANGES - If there is an increase or decrease in the cost of a benefit plan, the Plan may automatically change the amount of your premium election to cover the change in cost. If the cost change is a significant increase, you may be allowed to either make a new election of the higher cost or revoke your election, but you must elect similar coverage if available. If the cost change is a significant decrease, you may be allowed to commence participation of the option with a decrease in cost.
- SIGNIFICANT CURTAILMENT OF COVERAGE - If your coverage is markedly reduced or eliminated all together you may revoke your election and make a new election for similar coverage under a new benefit package option or drop coverage if no similar benefit package option is available. The loss of a physician in the network would not constitute significant curtailment of coverage.
- ADDITION (OR IMPROVEMENT) OF A PLAN OPTION PROVIDING SIMILAR COVERAGE - If during a period of coverage an option is added to the Plan (or an existing option is significantly improved), you may be allowed to elect the new option (or improved benefit option) prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- CHANGE IN COVERAGE OF SPOUSE OR DEPENDENT UNDER ANOTHER EMPLOYER PLAN - You may make an election change that is on account of and corresponds with a change in coverage under another employer plan (including a plan of the same employer or a plan of the spouse's for dependent's employer) if one of two conditions are met (a) the other Plan must permit participants to make an election change; or (b) the period of coverage under the employee's Plan is different from the period of coverage under the other employer plan.
- LOSS OF OTHER HEALTH COVERAGE - You may make an election to add coverage under the Plan if you or your covered dependents loses coverage under any group health coverage sponsored by a governmental or educational institution.
- FMLA LEAVE - You may change an election under the Plan upon FMLA and non-FMLA leave.
- EXCEPTION FOR COBRA QUALIFYING EVENTS - If you, your spouse or dependent gains or loses coverage due to a COBRA qualifying event, you may change your election to pay for the continuation of coverage on a pre-tax basis or to reduce your election for the corresponding loss of coverage.

- JUDGMENT, DECREE OR ORDER - If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires a change in accident or health coverage for your dependent child, you may make an election change to add or drop coverage as ordered.
- ENTITLEMENT TO MEDICARE OR MEDICAID - If you, your spouse or dependent becomes entitled to Medicare or Medicaid, you may make a prospective election change to cancel health coverage under this Plan. If you, your spouse or dependent loses coverage under Medicare or Medicaid, you may make a prospective election to begin or increase coverage under this Plan.
- HIPAA SPECIAL ENROLLMENT RIGHTS - If you gain the right to enroll in this Plan or to add coverage for a family member under the special enrollment rights of HIPAA, the Covered Person may revoke an election for coverage during a period of coverage and make a new election.

If you make a change in election, your new election amount will be effective the date of the qualifying event.

TERMINATION OF COVERAGE

Your coverage under this Plan shall terminate on the earliest of the following dates:

1. The date of termination of the Plan; or
2. The date you cease to be regularly scheduled as a full-time employee; or
3. The date you cease to be eligible for coverage under the Plan; or
4. The date you become a full-time member of the Armed Forces of any country; or
5. The date on which your employment is terminated unless otherwise stated in your contract.
6. The end of the month in which an active employee retires unless otherwise stated in your contract.

If you are not working because of an approved leave of absence, other than an approved Family and Medical Leave Act absence, or temporary layoff, your coverage will be continued until the end of the month next following the month in which the leave of absence or layoff commenced.

Your dependent's coverage will terminate at the end of the month the individual ceases to meet the definition of dependent as defined in the Plan, or the date your coverage is terminated.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT

COVERED EXPENSES

Covered expenses mean the amounts and limitations specified in the Schedule of Benefits for the services and supplies listed below, but only if the expenses are incurred after you or your dependent becomes covered and only to the extent that the services or supplies are recommended by an appropriate professional provider, are medically necessary for the care and treatment of an injury or sickness and are rendered by a covered facility or professional provider.

Facility Charges

1. Covered expenses for room and board are limited to the semiprivate room rate. Private room, intensive care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When room and board for other than semiprivate care is at the convenience of the patient, payment will be made only for semiprivate accommodations.

Facility ancillary expenses for necessary services and supplies, to include admission fees, use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a physician, or drugs or supplies not consumed or used in the facility.

The necessary services and supplies described above will also be covered when furnished by an ambulatory surgical facility, including all follow-up care within 72 hours of the procedure.

2. Confinement in a skilled nursing facility must commence within 7 days of a hospital stay of at least three days for the same cause or causes, not to exceed a total of 180 days of covered confinement during any 12 consecutive month period. To be covered, the facility must meet the definition of a skilled nursing facility in the Plan Document (available from your Employer). If your physician recommends care in a skilled nursing facility, be sure to call the Utilization Review nurse for approval of the admission.
3. Charges incurred through and billed by a home health care agency for the following services and supplies:
 - a. Part-time or intermittent skilled nursing care by a nurse;
 - b. Part-time or intermittent home health aide services for a patient who is receiving covered nursing or therapy services;

- c. Physical, respiratory, occupational, and speech therapy;
- d. Medical and surgical supplies;
- e. Oxygen and its administration;
- f. Medical social service consultations.

A visit by a member of a home health care team and four hours of home health aide service will each be considered one home health care visit.

No home health care benefits will be provided for dietician services, homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of durable medical equipment or prescription or nonprescription drugs or biologicals.

Home health care must be prescribed by the attending physician within 14 days following the covered person's discharge from a covered inpatient confinement of at least 3 days. Prior inpatient confinement is waived, however, if home health care is deemed medically necessary, ordered by a physician and is approved by the Plan as the least costly setting in which to receive covered treatment. If your physician recommends home health care, be sure to call the Utilization Review nurse for approval of the services.

- 4. Charges incurred through and billed by a hospice for the following services and supplies:
 - a. Inpatient care;
 - b. Nutrition counseling and special meals;
 - c. Part-time nursing;
 - d. Homemaker services;
 - e. Bereavement counseling for immediate family members during the six month period following the date of death, limited to a combined maximum of 6 visits (Immediate family members include husband, wife, and children);
 - f. Physical and chemical therapy.

To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under this provision of the Plan.

Hospice is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis. If your physician recommends hospice care, be sure to call the Utilization Review nurse for approval of the services.

Professional Charges

1. Surgery for the treatment of disease or injury, and sterilization procedures. Separate payment will not be made for inpatient pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

For related operations or procedures performed through the same incision or in the same operative field, the Plan shall pay the surgical allowance for the highest paying procedure plus 50% of the surgical allowance for the second highest paying procedure and 25% of the surgical allowance for each additional procedure.

When two or more unrelated operations or procedures are performed at the same operative session, the Plan shall consider as eligible the surgical allowance for each procedure.

Benefits may also be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

The Plan will pay surgical benefits for cutting procedures for the treatment of diseases, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist. Extraction and care of teeth and structures directly supporting the teeth are covered under the Dental Expense Benefit only.

The Plan will pay for certain surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal of infected toenails, and treatment of fractures and dislocations of bones of the foot. *Podiatry services not covered are those procedures considered to be routine foot care, unless a concurrent hazardous medical condition exists that prohibits the patient from performing the foot care him or herself.*

2. Administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, and provided the anesthesia is administered and charged for by a physician other than the operating surgeon or his assistant.

Anesthesia means the administration of spinal anesthetic, or the administration of rectal anesthetic, or the administration of a drug or other anesthetic agent by injection or inhalation, the purpose of which administration is the obtaining of muscular relaxation, loss of sensation, or loss of consciousness.

3. Medical care rendered by the professional provider in charge of the case to a covered person who is an inpatient in a covered facility for a condition not otherwise payable as surgery, maternity services, therapy services, or mental illness or chemical dependency care.

Such care includes inpatient intensive care rendered to a covered person whose condition requires a professional provider's constant attendance and treatment for a prolonged period of time.

Also included is care rendered to an inpatient of a covered facility by a professional provider whose particular skills are required for the treatment of complicated conditions. This does not include observation or reassurance of the covered person, stand-by services, routine pre-operative physical examinations or care routinely performed in the pre- or post-operative or pre- or post-natal periods or care required by a Facility Provider's rules and regulations.

4. Consultation services when rendered to an inpatient in a covered facility at the request of the attending professional provider. Consultations do not include staff consultations which are required by a facility provider's rules and regulations.

The Plan will pay for one such consultation per physician during any one inpatient confinement.

Other Charges

1. Charges for diagnostic services:
 - a. Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
 - b. Diagnostic laboratory and pathology tests.
 - c. Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
 - d. Pre-admission presurgical tests which are made prior to a covered person's inpatient or outpatient surgery.
 - e. Allergy testing consisting of percutaneous, intracutaneous and patch tests.
 - f. One PAP test per calendar year.
2. Charges for therapy services when used for the treatment of a sickness or injury to promote the recovery of the covered person. To be covered, the therapy services must be rendered in accordance with a physician's written treatment plan.
 - a. Radiation Therapy - the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
 - b. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included in this provision. However, oral chemotherapy is covered under the Prescription Drug Plan.

- c. Physical Therapy - the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function, and prevent disability following disease, injury or loss of body part.
 - d. Respiratory Therapy - the introduction of dry or moist gases into the lungs for treatment purposes.
 - e. Occupational Therapy - the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
 - f. Speech Therapy - the treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous therapeutic processes.
 - g. Dialysis Treatment - the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.
 - h. Cardiac Therapy – The services must be rendered in accordance with a Physician's written treatment plan and used for the treatment of a sickness or injury to promote recovery.
3. Emergency Services as follows:
- a. Emergency Accident Care

Facility and professional provider services and supplies for the initial treatment and all follow-up care of traumatic bodily injuries resulting from an accident.
 - b. Emergency Medical Care

Facility and professional provider services and supplies for the initial treatment of a sudden onset of a medical condition with severe symptoms requiring immediate medical attention.
4. Outpatient Surgery
5. Second Surgical Opinion - If your doctor believes you may need elective surgery, the Plan will provide payment in accordance with the Schedule of Benefits for a second surgical opinion consultation to determine the medical necessity of the procedure. Elective surgery is surgery which is not of an emergency or life threatening nature.

The second surgical opinion consultation must be rendered by a board certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is eligible under this benefit provision in cases where the second opinion disagrees with the first.

If you have a surgical procedure performed without receiving a second surgical opinion when it is required by the Utilization Review nurse, the Plan will pay only 50% of the benefits for charges by the surgeon.

6. Organ or Tissue Transplant - The Plan will pay covered expenses for human to human organ or tissue transplants incurred by you or your dependent as a recipient during a transplant benefit period which begins 5 days before and ends 18 months after the date of the organ or tissue transplant.

Covered expenses incurred by the donor of an organ or tissue for transplant are covered the same as any other sickness when the donor is a covered person under this Plan.

Covered expenses incurred by the donor of an organ or tissue for transplant when the donor is not a covered person under this Plan are covered to the extent of any benefits remaining after payment of the covered person's expenses as a recipient, when the donor's expenses are not covered under any group or individual insurance policy or benefit plan and are charged to the recipient.

The Plan will pay covered expenses for any combination of the following transplant procedures:

- a. Bone Marrow Transplant,
- b. Heart Transplant,
- c. Lung Transplant,
- d. Heart and Lung Transplant,
- e. Liver Transplant,
- f. Pancreas Transplant,
- g. Kidney Transplant, and
- h. Cornea Transplant.

Covered expenses include:

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a facility provider; and
- c. Treatment and surgery by a professional provider.

Drug therapy treatment to prevent rejection of the transplanted organ or tissue will be covered under the Prescription Drug Plan.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described above will be covered up to \$10,000 for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

If a covered transplant procedure is not done as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for organ or tissue procurement as described above.

7. Charges of a Facility and/or professional provider related to or because of a condition of pregnancy for female employees or spouses of male employees. Coverage is available to dependent daughters up to the age of 19.

Services rendered in a birthing facility are eligible provided the physician in charge is acting within the scope of his license and the birthing facility meets all legal requirements.

Midwife delivery services are eligible provided that the State in which such services are performed has legally recognized midwife delivery, and provided the midwife is licensed at the time delivery is performed.

8. Charges for newborn care. Nursery charges, other hospital services and supplies and physician's charges for hospital visits for newborn children.
9. Charges for temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment (including surgery), prescribed by a physician or dentist.

If a physician or dentist recommends a course of treatment for or in connection with temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment, a covered person may submit the treatment plan, including x-rays and study models, for pre-determination of benefits under the Plan. The Plan Supervisor will determine if the treatment is a covered expense and will notify the covered person.

10. Charges of a facility and/or professional provider related to or because of mental illness or chemical dependency (drug abuse and alcoholism). Covered expenses include:
- a. Inpatient facility charges;
 - b. Individual Psychotherapy;
 - c. Group Psychotherapy;
 - d. Psychological Testing;
 - e. Family Counseling: Counseling with family members to assist in the covered person's diagnosis and treatment
 - f. Convulsive Therapy Treatment -
Electroshock treatment or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Prescription drugs or medicines for the treatment of mental illness or chemical dependency will be covered under the Prescription Drug Plan.

In-patient treatment is limited to 30 days per calendar year.

11. Expenses for the services of a professional provider.

12. Expenses for the services of a nurse.

Nursing services must be rendered by a nurse who does not reside in your home, or who is not a member of your immediate family. To be covered, the physician in charge of the case must certify that the patient's condition requires care which can only be provided by an R.N. or L.P.N. and the Plan Supervisor must concur with the Physician's certification that is medically necessary.

13. Drugs and medicines requiring a written prescription order and which are approved for general use by the Food and Drug Administration, and prescribed insulin and syringes used by a diabetic. Such drugs and medicines covered under the Prescription Drug Plan will not be covered under the Comprehensive Medical Expense Benefit.

14. Rental or, at the discretion of the Plan, purchase of durable medical equipment which is prescribed by a professional provider and required for therapeutic use.

Claims for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be paid based

on the reasonable charge for the equipment which meets the patient's medical needs.

15. Charges for prosthetic devices (other than dental) to replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance.
16. Charges for orthotic devices (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), but excluding orthopedic shoes and other supportive devices for the feet.
17. Professional ambulance services when used to transport you or a covered dependent from the place of accidental injury or serious medical incident to the nearest facility where treatment can be given. Professional ambulance service is covered in a non-emergency situation only to transport the patient to or from a facility or between facilities for required treatment when such transportation is certified by the attending Physician as medically necessary.

Charges for transportation other than by ambulance will be covered if such expenses are for transportation within the continental limits of the United States and Canada, via public conveyance of:

- a. You or your dependent from his place of legal residence or local hospital to a specialized hospital or clinic, and return; or
 - b. You or your dependent from the area where a disability commences to his place of legal residence or local hospital.
18. Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth, or face occurring on or after the covered person's date of coverage. Injury as a result of chewing or biting shall not be considered an accidental injury.
 19. Surgical dressings and other medical supplies ordered by an appropriate professional provider in connection with medical treatment, but not common first-aid supplies.
 20. Charges for detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Chiropractic visits are limited to 30 per calendar year.
 21. Routine childhood immunizations and booster doses of all immunizing agents used in childhood immunizations for all eligible children. No deductible will be taken for covered immunization expenses.

22. Breast Reconstruction in accordance with the Women's Health and Cancer Rights Act the following coverage is offered to a Covered Person who elects the following services in connection with a mastectomy:
- Reconstruction of the breast on which the mastectomy has been performed;
 - Surgery and reconstruction of the other breast to produce symmetrical appearance; and
 - Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.
21. Acupuncture – The insertion of needles into the human body to control the flow and balance of energy in the body and to cure and relieve any ailment or disease of the mind or body or any wound, bodily injury or deformity.
22. Chiropractic Care – Modalities (hot, cold therapy, etc.) manipulation and adjunctive therapy by a Covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, abnormal spacing, sprain or strain.
23. Sleep Disorders – Care and treatment for sleep disorders when deemed Medically Necessary.
24. Morbid Obesity – Physician services for diagnosed morbid obesity including medically necessary gastric bypass surgery.
25. Routine examinations for covered employees and dependents are covered as follows:
- a. One routine physical examination, including related tests, per individual per calendar year.
 - b. One routine gynecological examination, including pap smear, per covered female per calendar year.
 - c. One routine mammogram (breast x-ray) per covered female age 40 and over per calendar year. One routine mammogram per covered female under age 40 per calendar year will be covered if recommended by a Physician.
26. Infertility charges for the diagnosis and treatment of the medical condition causing infertility. This does not include embryo transfer procedures or infertility related supplies and other services including, but is not limited to, in-vitro fertilization, GIFT, ZIFT, artificial insemination, donor sperm, oral or injectable forms of infertility treatment.

CASH DEDUCTIBLE

The Comprehensive Medical Deductible applies only once during a calendar year to each covered person's covered expenses. **Your family, however, will not be required to meet more than 2 times the individual deductible amount in any calendar year.** Any number of family members may help to meet the family deductible amount, but no more than the individual deductible amount will be taken from any one family member's expenses.

So that your medical expenses will not be subject to a deductible late in one calendar year and soon again in the following year, any expenses incurred against the deductible in the last three months of a calendar year may also be applied against the deductible for the next calendar year.

If two or more family members receive injuries in the same accident, and, as a result of these injuries, incur covered expenses, only one deductible amount will be deducted from the total covered expenses incurred as a result of these injuries. If you acquire two or more children as a result of a multiple birth and if you incur covered expenses for those children as a result of premature birth, abnormal congenital condition or sickness commencing or injury received not more than 30 days after their birth, only one deductible amount will be deducted from the total covered expenses incurred for those children as a result of the multiple birth.

BENEFIT PERCENTAGE

After the deductible is satisfied, the Plan pays the percentages listed in the Schedule of Benefits for covered expenses each calendar year.

If, during a calendar year, you or a dependent incurs covered expenses in excess of the Out-of-Pocket Maximum as indicated in the Schedule of Benefits, excluding charges for psychiatric and chemical dependency care, the amount payable for covered expenses incurred by such individual (or family) during the remainder of the calendar year will be 100%. Any number of family members may help to meet the family Out-of-Pocket Maximum amount, but no more than the individual Out-of-Pocket Maximum amount will be taken from any one family member's expenses.

PROGRAM MAXIMUM

The maximum amount available for all injuries or sicknesses for each individual covered under the Plan is shown in the Schedule of Benefits.

If on January 1, the maximum amount available has been reduced by \$1,000 in benefit payments, the maximum amount will be reinstated upon receipt of satisfactory medical evidence. Amounts incurred for psychiatric and chemical dependency care will not be used to calculate this restoration of maximum.

MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under this Plan:

1. For or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit;
2. For or in connection with a sickness or injury for which you or your dependent is eligible or covered under Workers' Compensation or similar law;
3. For services provided without cost by any governmental agency, except where such exclusion is prohibited by law;
4. For charges the covered person has no obligation to pay;
5. For charges made which are in excess of Reasonable and Customary charges (except as may be specifically provided herein), or for care or treatment not medically necessary-;
6. To the extent that you or your dependent is reimbursed or in any way indemnified for those expenses by or through Medicare or any other public program;
7. For services, treatment or supplies for which no charge would usually be made or for which such charge, if made, would not usually be collected if no coverage existed; or for services, treatment or supplies to the extent that charges for the care exceed the charge that would have been made and collected if no coverage existed;
8. For custodial care, domiciliary care or rest cures;
9. For education or training programs regardless of diagnosis or symptoms that may be present, except as specifically provided in this Plan;
10. For travel, whether or not recommended by a physician, except as specifically provided in this Plan;
11. For any treatment, confinement, or service which is not recommended by, or any operation which is not performed by, an appropriate professional provider;
12. For routine or periodic physical examination and related x-ray and laboratory expenses (except as may be specifically provided herein), or nutritional supplements;
13. For injury sustained or sickness contracted while committing or attempting to commit an assault or felony;
14. For services performed by a physician or other professional provider enrolled in an education or training program when such services are related to the education or training program;

15. For biofeedback, unless performed by a physician certified to perform such services;
16. For expenses related to reversal of a sterilization operation, surrogate mother, or a sex change operation;
17. For wigs, artificial hair pieces, human or artificial hair transplants, or any drug -- prescription or otherwise -- used to eliminate baldness.
18. For injury sustained or sickness contracted while on active duty in military service;
19. For injury sustained or sickness contracted as the result of or caused by any act of war, or participation in a riot or civil disobedience;
20. For any expenses incurred as a result of or in connection with treatment that is experimental/investigative in nature including drugs, medicines, treatments, procedures and therapies. A drug or medicine will be considered experimental unless, at the time it is provided, it is commercially available and approved for general use by the United States Food and Drug Administration as effective for treatment or diagnosis of the condition for which the charge is made. The approval must not be on a limited or an experimental basis. A treatment, procedure or therapy will be considered experimental unless at the time it is provided or performed, it is considered effective for the treatment or diagnosis of the condition for which the charge is made. The treatment, procedure or therapy must not be considered effective on a limited or an experimental basis.;
21. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;
22. For palliative or cosmetic foot care such as treatment of flat feet conditions, subluxations of the foot, corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet except where surgery is performed (see surgery provision);
23. For equipment that does not meet the definition of durable medical equipment, including but not limited to: air conditioners, humidifiers, exercise equipment, etc., whether or not recommended by a Physician;
24. For cosmetic surgery unless the covered person receives an injury, while covered under the Plan, which requires the surgery;
25. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury); and except for such benefits provided by the Plan under the VISION CARE EXPENSE BENEFIT section of this booklet;

26. For oral surgery or dental treatment except as specifically provided in this booklet;
27. For hearing aids or examinations for the prescription or fitting of hearing aids;
28. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
29. For expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motordriven cycle, and motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a covered person who is a non-driver when involved in an uninsured motor vehicle accident.

For purpose of this exclusion, a non-driver is defined as a covered person who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle;

30. For pre-existing conditions that were being treated within 90 days prior to the date of coverage or, except for a timely return from leave of absence or temporary layoff, the most recent re-employment date. If you or your dependent does not receive medical care or services or is not under a professional provider's care with respect to the pre-existing (or related) condition for a period of 6 consecutive months while covered under the Plan, the pre-existing condition limitation will no longer apply and any covered charges incurred after the treatment –free period are allowable. When you or your dependent is covered under the Plan for a period of 12 consecutive months, the pre-existing condition limitation will no longer apply and all covered charges incurred thereafter will be considered eligible. This provision does not apply to those individuals covered under the prior plan immediately prior to the effective date.

The Health Insurance Portability and Accountability Act of 1996 provides the following exceptions to pre-existing condition exclusions:

- Pre-existing condition exclusions may not apply to newborns;
- Pre-existing condition exclusions may not apply to adopted children enrolled in a plan within 30 days. The exception to pre-existing condition exclusions for adopted children, does not apply to coverage provided before the date of adoption or placement for adoption; and
- Pregnancy may not be considered a pre-existing condition.

*Enrollment date is the first day of coverage, or the first day of waiting period if there is a waiting period.

Portability of Coverage

A Covered Person will receive credit toward satisfaction of the pre-existing condition limitation described in this section for the time he/she was covered under another health plan, but only if:

- Your service begins after the effective date of this Plan; and
- The person was covered, under another health plan that meets the definition of “Creditable Coverage”, within the 63-day period just before his or her enrollment date under this Plan.

Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 63-day period.

If the Covered Person was covered for a period of time under creditable coverage that is:

- Greater than or equal to the time periods referred to in the pre-existing conditions limitation described in this section, then the pre-existing conditions limitation periods will not apply to the person.
- Less than the time periods referred to in the pre-existing conditions limitation described in this section, then the pre-existing conditions limitation periods will be reduced by the number of consecutive days that the person was covered under creditable coverage.

However, for a child who became covered under creditable coverage within 31 days of birth, the pre-existing conditions limitation periods will not apply regardless of how long the child was covered under creditable coverage.

“Creditable Coverage” is defined as coverage under a group health plan, COBRA continuation coverage, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, foreign country public coverage, State Children’s Health Insurance Program, a medical program of the Indian Health Service or a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

Significant Break in Coverage – A period of 63 days or more during which an Employee or Dependent is not covered by any creditable coverage. Waiting periods are not included in the calculation of the break in coverage period.

It is your responsibility to provide information about creditable coverage in order for the pre-existing conditions limitation under this Plan to be reduced or waived.

Certificates of creditable coverage may be obtained, free of charge, from a Covered Person's group health plan when coverage under a plan is lost, when a Covered Person becomes entitled to elect COBRA continuation coverage, or when COBRA continuation coverage ceases. The request may be made before a Covered Person loses coverage, or within 24 months after losing coverage. The request can be made through either The Loomis Company or The Reading School District.

The Loomis Company
Eligibility Department
P. O. Box 7011
Wyomissing, PA 19610-6011
(610) 374-4040

Reading School District
800 Washington Street
Reading, PA 19601

31. For expenses related to the use of hypnosis, except when used to treat a medical condition;
32. For services provided to an HMO participant by a facility or professional provider which is not a member of that HMO;
33. For a charge refused by another plan as a penalty assessed due to noncompliance with that plan's rules and regulations;
34. For prescription drugs that are covered under the Employer's Prescription Drug Plan, or for the Prescription Drug Cash Deductible applicable thereto;
35. For expenses related to invitro fertilization.
36. For any other service or supply except as specifically provided herein.
37. Self-Inflicted, any intentionally self-inflicted injury or illness. In compliance with the Health Insurance Portability and Accountability Act, if an injury (including self-inflicted injury) results from a medical condition or act of domestic violence, the Plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.
38. For elective termination (abortion) of a pregnancy and all associated expenses.
39. Diabetic management – including training and educational self-management programs.
40. Smoking Cessation – care and treatment for smoking cessation programs, is including, but not limited to, smoking deterrent patches and smoking deterrent gums. Unless medically necessary due to a severe active lung illness such as emphysema or asthma.
41. Obesity – treatment for expenses incurred specific to obesity due to overeating, weight reduction, dietary or weight control. Medically Necessary charges for Morbid Obesity will be covered by the Plan.

DENTAL EXPENSE BENEFIT

Upon receipt of proof satisfactory to the Plan Supervisor that you or your dependent has incurred dental expenses for the treatment of a sickness or preventive dental care, the Plan will pay the charges in accordance with the Schedule of Benefits and the provisions outlined herein.

COVERED DENTAL EXPENSES

Covered dental expenses are the charges of a dentist for services and supplies listed below required for dental care and treatment of any sickness or for preventive dental care. Not included is any charge in excess of \$25 over the Reasonable and Customary charge:

1. For similar services and supplies by dentists or physicians in the locality concerned; or
2. Where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

Class I Services -- Diagnostic and Preventive

1. Oral examinations, including prophylaxis (scaling and cleaning of teeth), limited to two exams per calendar year.
2. Dental x-rays, including full mouth x-rays (but not more than once in any period of 36 consecutive months), supplementary bitewing x-rays (but not more than once in any period of 6 consecutive months) and other dental x-rays required in connection with the diagnosis of a specific condition requiring treatment.
3. Topical application of stannous fluoride for children under 19 years of age (no more than one treatment in any 6 consecutive month period).
4. Space maintainers, fixed appliance, for children under 19 years of age (not made of precious metals); limited to initial appliance only.
5. Palliative emergency treatment of an acute condition requiring immediate care.

Class II Services - Basic Restorative: Fillings, Endodontics, Periodontics, Maintenance of Prosthodontics and Oral Surgery

1. General anesthesia (only when medically necessary and in connection with covered oral surgery).

2. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth.
3. Endodontics, including pulpotomy, direct pulp capping and root canal therapy.
4. Apicoectomy (dental root resection).
5. Alveolectomy (preparation of the mouth for dentures).
6. Gingivectomy, gingivoplasty, gingival curettage and mucogingival surgery.
7. Osseous (bone) surgery in connection with periodontal disease, including flap entry and closure.
8. Periodontal scaling and root planing.
9. Repairs and adjustments to full or partial dentures.
10. Relining and rebasing of full or partial dentures, but not more than once in any period of 24 consecutive months.
11. Replace broken tooth on complete or partial denture, not in conjunction with other repairs.
12. Simple extraction.
13. Surgical extraction, including soft tissue and full or partial bone impacted.
14. Biopsy of hard or soft oral tissue.
15. Surgical removal of maxillary or mandibular infrabony cysts.
16. Consultation by a specialist when referred by the attending Dentist, limited to one consultation per consultant.

Class III Services -- Major Restorative: Installation of Full and Partial Dentures, Fixed Bridgework and Crown, Inlay and Onlay Restorations

1. Crowns, inlays, onlays, bridges and dentures shall be considered completed on the date they are firmly inserted.
 - a. Single, unconnected crown, inlay and onlay restorations to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain or composite filling.

- b. Initial installation of fixed bridgework (including inlays and crowns as abutments) to replace one or more natural teeth extracted while the individual is covered under this Dental Plan or a prior dental plan of the employer.
- c. Initial installation of partial or full removable dentures to replace one or more natural teeth extracted while the individual is covered under this Dental Plan or a prior dental plan of the employer.
- d. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to a fixed bridgework, but only if satisfactory evidence is presented that:
 - The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed, and while the individual was covered under this Dental Plan or a prior dental plan of the Employer.
 - The existing denture or bridgework cannot be made serviceable and at least 5 years have elapsed prior to its replacement.

Normally dentures will be replaced by dentures but if a professionally adequate result can be achieved only with bridgework, charges for such bridgework will be included as covered dental expenses.

- e. Repair or recementing of crowns, inlays, onlays, or bridgework.

The Following Limits Apply To Class III Services:

1. Restorative

- a. Gold, baked porcelain restorations, crowns and jackets -If a tooth can be restored with a material such as amalgam and the patient and the dentist select another type of restoration, the covered dental expenses for the procedure actually performed will be limited to the reasonable charges appropriate to the procedure using amalgam or similar material.
- b. Reconstruction - Covered dental expenses will include only charges for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension or restore the occlusion are not covered.

2. Prosthodontics

- a. Partial dentures - If a cast chrome or acrylic partial denture will restore a dental arch satisfactorily and the patient and the dentist select a more elaborate or precision appliance, the covered dental expenses for the procedure performed will be limited to the reasonable charges appropriate to the cast chrome or acrylic denture.
- b. Complete dentures - If, in the provision of complete denture services, the patient and the dentist decide on personalized restorations or specialized techniques as opposed to a standard procedure, the covered dental expenses for the procedure actually performed will be limited to the reasonable charges appropriate to the standard procedure.
- c. Replacement of existing dentures - Charges for replacement of an existing denture can be included as a covered dental expense only if the existing denture is not serviceable and cannot be made serviceable. Otherwise, the covered dental expenses for the replacement will be limited to the reasonable charge appropriate for those services which would be necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be covered only if at least 5 years have elapsed since the date of the initial installation of that appliance.
- d. Adjustment of prosthetic appliances - Charges for adjustments of prosthetic appliances within six months of initial installation are included in the cost of such appliance, and will not be paid for separately.
- e. Precious metal dentures - Payment of the applicable Plan allowance for a nonprecious metal denture will be made toward the charge for the precious metal denture selected by the covered person. The Plan will make no payment for the cost difference between precious and non-precious metal dentures. The balance of the charge remains the responsibility of the covered person.

Class IV Services - Orthodontics for Adults and Children

Each month of active treatment is considered a separate Dental Service.

1. Comprehensive full banded orthodontic treatment including:
 - a. Preliminary study including cephalometric radiographs, diagnostic casts and treatment plans
 - b. First month of active treatment including all active and retention appliances

- c. Active treatment per month after the first month
 - d. Retention and observation treatment, per visit
- 2. Orthodontic Treatment (no more than one appliance per individual) including:
 - a. Fixed or cemented appliance for tooth guidance.
 - b. Fixed or cemented appliance to control harmful habits.
 - c. Fixed or cemented retention appliance.

The Following Limitations Apply To Class IV Services.

- 1. The obligation of the Plan to make monthly or other periodic payments for an orthodontia treatment plan begun prior to the eligibility of the patient shall commence with the first payment due following one month of participation under this Plan. The maximum amount payable by the Plan for orthodontia will apply fully to this and subsequent payments.
- 2. The Plan's obligation to make monthly or other periodic payments for an orthodontia treatment plan shall cease on the payment due date next following termination of treatment for any reason prior to completion of the case, the date the covered employee or dependent loses eligibility, or the termination date of the Plan, whichever shall first occur.
- 3. X-rays and extraction procedures incidental to Orthodontia are not covered Orthodontia benefits but are covered under Class I or Class II services.
- 4. The Plan's liability shall be payable over a period not to exceed the length of the approved treatment plan. The initial payment shall be equal to no more than 25% of the total Plan liability. The remaining 75% of the Plan's liability will be payable in equal quarterly installments during the period covered by the approved treatment plan and while the covered person's coverage is in effect. If the treatment plan is satisfactorily completed in less than the period specified in the approved treatment plan, the Plan shall upon appropriate notification from the dentist, make payment in the amount of the remainder of the Plan's liability.
- 5. Predetermination by the Plan is required for all orthodontic services.

CASH DEDUCTIBLE

The amount of the cash deductible is specified in the Schedule of Benefits. It applies separately to you and each of your dependents each calendar year. If 2 or more members of your family are injured in the same accident, only one deductible will be

applied each year against all the covered dental charges incurred as a result of such accident.

Any covered dental expenses incurred during the last three months of a calendar year that are used to satisfy an individual's deductible in full or in part will not be used toward satisfaction of the individual's deductible for the following calendar year.

BENEFIT PERCENTAGE

The percentage amount shared by the Plan and the employee or dependent as specified in the Schedule of Benefits.

MAXIMUM AMOUNT

The maximum amount available for all dental expenses for each individual covered under the Plan is specified in the Schedule of Benefits.

PRE-TREATMENT REVIEW

One of the advantages of this Dental plan is that you can find out how much will be paid by the plan before you have the dentist do extensive work. This will eliminate misunderstandings as to what is covered by the plan and so enable you to avoid underestimating what you may owe the Dentist. The procedure is called Predetermination of Benefits and here is how it works.

Customarily before starting extensive work, the dentist will tell you what work needs to be done (Dentists usually call this the Treatment Plan). This simply secures the information in writing so that the Plan Supervisor may indicate, in advance, the benefits allowable as well as your portion of the dentist's charge.

Predetermination of Benefits may be filed when the dentist's estimated charge is \$100 or more. Dental care can be expensive and it is to your advantage to know the benefits before you agree to have the work done.

Predetermination of Benefits is not a Guarantee of Payment. Actual Claim Payment will be based on the Coverage in Effect on the Date Each Service is performed.

ALTERNATE TREATMENT

If alternate services or supplies may be used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the disease or injury and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the covered person's total current oral condition.

DENTAL DEFINITIONS

1. Dentist - A Doctor of Dental Surgery, Doctor of Dental Medicine, Doctor of Medicine or Doctor of Osteopathy.
2. Dental Expense - An expense is incurred when the service is performed, except that it is deemed to be incurred when
 - a. The impression is taken, in the case of dentures or fixed bridgework;
 - b. Preparation of the tooth is begun, in the case of crown work;
 - c. Work on the tooth is begun, in the case of root canal therapy.
3. Treatment Plan - A written report made by a dentist describing the findings of the examination of a covered person and recommended treatment for the person's dental disease, defect or accident causing injury to teeth.
4. Course of Orthodontic Treatment - A period which begins when the first orthodontic appliance is installed on a covered person and ends when the last orthodontic appliance is removed. Successive courses of orthodontic treatment shall be considered as one course of orthodontic treatment, unless the succeeding course begins more than two years after the end of the preceding course.

DENTAL EXCLUSIONS

Not covered under any section of this benefit are charges for:

1. Any dental services and supplies which are covered expenses in whole or in part under any other plan or group benefits provided by the employer;
2. Anything not furnished by a dentist, except X-rays ordered by a dentist, and services by a licensed dental hygienist under the dentist's supervision; anything not necessary or not customarily provided for dental care;
3. Veneers or similar properties of crowns and pontics placed on or replacing teeth, other than 10 upper and lower anterior teeth;
4. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
5. Services a) furnished by or for the U. S. Government, or b) by or for any other government unless payment is legally required, or c) to the extent provided under any governmental program or law under which the individual is, or could be, covered;

6. An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered;
7. Prosthetic devices (including bridges, dentures), crowns, inlays, and onlays and the fitting thereof, which were ordered while the individual was covered under this Dental Plan but are finally installed or delivered to such individual more than 30 days after termination of coverage;

Ordered, in the case of dentures, means that impressions have been taken from which the denture will be prepared; and, in the case of fixed bridgework, restorative crowns, inlays and onlays, means that the teeth which will serve as retainers or support or which are being restored have been fully prepared to receive the item, and impressions have been taken from which bridgework, crowns, inlays and onlays will be prepared;

8. Services due to an accident relating to employment or disease covered under Worker's Compensation or similar law;
9. Replacement of duplicate, lost, missing or stolen appliances or prosthetic device; appliances or restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion;
10. Charges for sealants, oral hygiene, plaque control program, and dietary instructions;
11. Implantology (an artificial root inserted into the alveolar bone to form an abutment on which a restoration, for example a crown or bridge, can be placed);
12. Services or supplies which are not appropriate or which do not meet professionally recognized standards of quality;
13. Services rendered through a medical department, clinic, or similar facility provided or maintained by the individual's Employer;
14. Failure to keep a scheduled visit with the dentist and charges for the completion of insurance forms;
15. Services and supplies which the employee or dependent receives without an obligation to pay,
16. Treatment of temporomandibular joint syndrome with intra-oral prosthetic devices or any other method to alter vertical dimension;
17. Any services or supplies which are not dental services or supplies;

18. Any other services and supplies except as described in this booklet.

Other exclusions and limitations are set forth in the MEDICAL EXCLUSIONS AND LIMITATIONS section of this booklet. Any excess of a covered expense is not eligible under the Comprehensive Medical Expense Benefit.

VISION CARE EXPENSE BENEFIT

Upon receipt of proof satisfactory to the Plan Supervisor that you or your dependent has incurred necessary covered expenses for visual services and supplies, the Plan will provide benefits as described below. Charges in excess of the Reasonable and Customary charge will not be considered covered expenses.

VISION CARE SERVICES AND SUPPLIES

Complete Eye Examination and Refraction	100% of Reasonable and Customary
Post-Refractive Services:	
Lenses in Frames (per pair)	
• Single Vision	\$ 24
• Bifocal	\$ 32
• Trifocal	\$ 46
• Aphakic (replaces natural lens of eye)	\$110
Frames	\$ 24
Contact Lenses (per pair) Medically Necessary	
• Hard	\$100
• Soft	\$150
• If otherwise prescribed	\$ 50

LIMITATIONS

Payment for covered expenses will be limited in the following manner.

1. Payment for an eye examination and refraction is limited to a) one during a 11-month period for individuals under 19 years of age; and b) one during a 23-month period for individuals 19 years of age and older.
2. Payment for post-refractive services is limited to a) one during an 11-month period for individuals under 19 years of age; and b) one during a 23-month period for individuals 19 years of age and older.
3. Regardless of the age of the individual, payment is limited to one set of frames in any 23-month period.
4. Contact lenses shall be considered medically necessary only after cataract surgery, corneal transplant surgery, or other conditions such as, but not limited to, Keratoconus if indicated, or when visual acuity is not correctable to 20/70 in the better eye by use of lenses in a frame but can be improved to 20/70 or better by the use of contact lenses.

5. Payment for an initial pair of lenses will be made only when there is an axis change of 20 degrees or .50 diopter sphere or cylinder change, and these lenses must improve vision acuity by at least one line on the standard chart. (Adherence to this general standard is subject to professional judgement on an individual case basis).

Payment for the subsequent change in lenses will be made only if the criteria established above is met and will not be made more than once every 11 months for individuals under 19 years of age and not more than once every 23 months for individuals 19 years of age or older.

6. In cases involving services in which the provider and patient elect to utilize photo grey or light sensitive lenses, the Plan will provide benefits, but will not provide any additional payment in excess of the amount listed in the Schedule of Benefits for lenses.
7. Payment for frames, lenses and/or contact lenses will be made only if prescribed by a physician or optometrist.

The time periods described above will begin on the first date of service for such item that is eligible under this benefit.

VISION EXCLUSIONS

Not covered under this benefit are charges for:

1. Any lenses which do not require a prescription;
2. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames;
3. Sunglasses, whether or not requiring a prescription (tinted glasses with a tint other than Number 1 or Number 2 are considered to be sunglasses for the purpose of this exclusion), industrial safety glasses and safety goggles;
4. Prescribed contact lenses for cosmetic convenience, except as provided in the Schedule of Benefits;
5. Medical or surgical treatment of the eye;
6. Diagnostic services;
7. Orthoptics, vision training or subnormal vision aides;
8. Any other services or supplies except as specifically described herein.

PRESCRIPTION DRUG EXPENSE BENEFIT

If you or a dependent incurs expense for prescription drugs, the Plan will pay the Reasonable and Customary expense which is in excess of the Prescription Drug Cash Deductible shown in the Schedule of Benefits. The Prescription Drug Cash Deductible applies separately to each prescription and refill.

To be covered, prescription drugs must be purchased from a licensed pharmacist, and while this benefit applies to the person for whom they are purchased.

DRUGS COVERED

1. Legend drugs (drugs which require a prescription under federal or state law);
2. Compounded medication of which at least one ingredient is a prescription legend drug;
3. Oral contraceptives, regardless of the reason prescribed;
4. Insulin; and
5. Any other drug which under the applicable state law may only be dispensed upon the written prescription of a qualified prescriber.

PRESCRIPTION EXCLUSIONS

Not covered under this benefit are charges for:

1. Any substance, except insulin, which may be lawfully obtained without a prescription;
2. Administration of any prescription drug, insulin, or other substance;
3. Any prescription refill in excess of that specified by the prescriber or dispensed more than 12 months after it was prescribed;
4. The amount of any prescription or refill exceeding the greater of a 34-day supply or 100 unit doses for prescription drugs purchased at a pharmacy; the amount of any prescription or refill exceeding a 90-day supply for prescription drugs purchased through the mail service pharmacy;
5. Any prescription directing enteral or parenteral administration of nutrition therapy;
6. Any experimental drug or any drug which may not lawfully be dispensed in the United States of America;

7. Any medication to be taken by or administered to a person while he or she is a patient at a hospital, nursing home or similar institution which operates or allows to be operated on its premises a pharmacy or other facility for dispensing drugs;
8. Any therapeutic device or appliance, including syringes (but excluding insulin syringes), support garments, prostheses and contraceptive devices or materials, regardless of their intended use;
9. Any immunization agent, biological serum, blood or blood plasma;
10. Any drug, prescription or otherwise, used to eliminate baldness.

Any prescription drug covered under this Plan will not be covered under the Comprehensive Medical Expense Benefit, including the Prescription Drug Cash Deductible.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that continuation of employer-sponsored health care coverage be made available to formerly covered employees and dependents for a specified period of time at their own expense. If you become ineligible for coverage as the result of a change in your employment status, your coverage ends on the date of termination. You may choose to continue coverage if you lose your group health coverage because of a reduction in hours scheduled or because of termination for reasons other than gross misconduct.

A covered spouse of an employee may elect to continue coverage under The Reading School District Health Care Plan on a self-pay basis if group health coverage lost for any of the following reasons:

- The death of the employee;
- The termination of the employee's employment for other than gross misconduct or reduction in the employee's hours of employment;
- Divorce or legal separation from the employee;
- The employee becomes entitled to Medicare; or

In the case of a dependent child of an employee covered by The Reading School District Health Care Plan, he or she may choose to continue coverage on a self-pay basis if group health coverage under the Plan is lost for any of the following reasons:

- The death of the employee;
- The termination of the employee's employment for other than gross misconduct or reduction in a parent's hours of employment;
- Parents divorce or legal separation;
- The employee becomes entitled to Medicare;
- The dependent ceases to be a "dependent child" as defined under The Reading School District Health Care Plan; or

The employee or the eligible family member has the responsibility to inform the Human Resources Department of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. It is the responsibility of the Human Resources Department to notify the COBRA Administrator within 30 days of an employee's termination of employment, reduction in hours, Medicare entitlement, or death. Children

born to, or placed for adoption with a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage.

You will be notified of your rights to continue coverage on a self-pay basis. You have at least sixty days from the date of the notice of your COBRA continuation of coverage rights to elect COBRA continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end as of the date you became ineligible to continue as a covered member of The Reading School District Health Care Plan.

If an employee becomes ineligible for employer paid health care coverage because of a reduction in hours scheduled or because of voluntary resignation, the employee's continuation of coverage on a self-pay basis may last for up to 18 months. The 18 months may be extended to 29 months if a qualified beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at any time within the first 60 days of continuation coverage. To benefit from this extension, you must notify the Plan administrator of the disability determination within 60 days after the determination, and prior to the expiration of the initial 18-month COBRA period. The affected individual also must notify the Plan administrator within 30 days of any final determination that the individual is no longer disabled. Also, when dependents become ineligible for coverage under the Plan, they may generally choose to continue coverage on a self-pay basis for up to 36 months. A second qualifying event may also extend the 18 months to 36 months for qualified beneficiaries.

Although an employee or eligible dependent may elect to continue coverage as outlined above, this period may be reduced because of any of the following events:

- The employer no longer provides group health coverage to any of its employees;
- The premium is not paid within the 45-day grace period following the election of COBRA continuation coverage;
- The premium for your continuation coverage is not paid; (the premium is due on the first of each month and will not be accepted after the thirtieth calendar day after the due date);
- You become an employee covered under another group health plan (the Covered Person may be able to maintain continuation of coverage if there is a pre-existing condition clause that would limit your coverage under the other group plan);
- You or a covered dependent becomes entitled to Medicare;
- You were divorced from a covered employee and subsequently remarry, and are covered under your new spouse's group health plan.

If an employee or covered dependent elects to continue coverage on a self-pay basis, they may do so without proving insurability. However, if the election is not made within 60 days, health care coverage under the Plan will terminate retroactively to the day of the qualifying

event. Further if the eligible employee or eligible dependent fails to make the initial COBRA continuation coverage premium payment within the 45-day grace period following the election of COBRA coverage they will be deemed ineligible for COBRA continuation coverage.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

The Plan Administrator reserves the right to terminate Plan coverage retroactively to the date the employee or covered dependent lost their eligibility under the terms of the employer-sponsored health care plan. This section of the Summary Plan Description is a summary of a very complicated law. In the event of any inconsistency between this Notice and federal law, federal law will take precedence.

If You Have Questions

If you have questions about your COBRA coverage, you should contact The COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

FAMILY SECURITY BENEFIT

The Family Security Benefit is designed to provide continuous coverage during the adjustment period that occurs within a family following the death of the employee.

Medical, dental, and vision care coverage for your dependents, which is in force at the time of your death, will continue without contribution until the earliest of the following:

- Remarriage of your spouse;
- Termination of dependent status;
- 6 months from the date of your death;
- Date your dependent becomes eligible for Medicare;
- Termination of the Plan.

NOTE: If continuation of Coverage under COBRA is elected, this Family Security Benefit will be part of, not in addition to, the continuation period thereunder.

MEDICAL CARE CONVERSION PRIVILEGE

When your medical care coverage under this Plan terminates, the medical benefits may be converted to an individual policy.

The conversion privilege is available:

- To you, if your coverage terminates after having been covered for at least three months under this Plan.
- To your dependent spouse if the coverage terminates because of your death, or because of divorce or annulment of marriage, provided your dependent spouse is not a covered person under a similar group health insurance policy or plan.
- To your dependent children if their coverage terminates because of your death, provided your spouse is not eligible to exchange the group medical care coverage for an individual policy, or because of the dependent child's marriage or attainment of the maximum age limit.

The conversion privilege is not available to you or your dependents who are eligible for Medicare. Any dependents covered under this Plan will be covered under the individual policy.

Application and payment of the first premium must be made to the insurance company designated by the Plan Administrator within 31 days immediately following termination of insurance under this Plan.

Note: If Continuation of Coverage under COBRA is elected, this conversion privilege will apply at the end of the maximum continuation period thereunder.

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the employee's inability to perform the functions of his or her job due to the employee's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

Under the law, employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The Reading School District will consider the 12-month period to begin on the date the employee's FMLA leave first begins.

It is the employee's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by your employer. When the need for leave is foreseeable, the employee must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations. If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Human Resource Department.

MILITARY LEAVE OF ABSENCE

In the event an employee, who is a member of the United States Armed Forces Reserves, is called to active duty he may elect to continue Plan coverage for up to 24 months, beginning on the date the employee's absence starts. The employee may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the employee's share, if any, for the coverage. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Human Resources Department.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

COORDINATION OF BENEFITS

This Plan has been designed to help meet the costs of sickness or injury. Since it is not intended that greater benefits be paid to you than your actual medical expenses, the amount of benefits payable under this Plan will be reduced by taking into account any coverage which you or your dependents have under other plans. The benefits under this Plan will be reduced by the amount of benefits payable under the other plans.

This Plan will always pay either the regular benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100 percent of allowable expenses.

Allowable expenses mean any necessary, Reasonable and Customary expenses incurred while you are eligible for benefits under this Plan, part or all of which would be covered under any of the plans, but not any expenses contained in the list of Exclusions. Allowable expenses will not include charges for services provided to an HMO participant by a facility or professional provider which is not a Member of that HMO, nor include charges refused by another plan as a penalty assessed due to non-compliance with that plan's rules and regulations. Plan means any plan providing benefits or services for or by reason of medical, dental or vision care or treatment, which benefits or services are provided by group insurance, Medicare, self-insurance, or any similar plan or program and coverage under automobile insurance.

When benefits are available under another plan or plans, this Plan will pay after any other plan which:

- Is automobile insurance; or
- Does not have coordination or non-duplication rules; or
- Covers the claimant as an active employee; or
- For a child, covers the parent whose birthday (month and day, but not year) falls first in each year. When the parents are divorced, this Plan will pay after that of the natural or stepparent with custody of the child or court-decreed financial responsibility for the child's health care expenses.

ELIGIBLE SPOUSE RULE (FOR ACTIVE EMPLOYEES)

This Plan is the secondary payer of benefits for a spouse eligible for coverage through another employer's group benefit plan. Benefits from this Plan will coordinate its benefits against those of the best benefit option available to the spouse by that employer for medical expenses, whether or not selected for coverage.

AUTOMOBILE BENEFITS

This Plan is not eligible to be elected as primary coverage in lieu of automobile benefits. Payments from automobile insurance will always be primary and this Plan shall be secondary only.

EFFECT OF MEDICARE

For active employees and/or their dependents who are eligible for Medicare, this Plan will be primary and Medicare secondary.

EFFECT OF EXCLUSIONS

The provisions of this section shall not be construed to create any independent right to payment of any benefit under this Plan. Any exclusion or limitation contained in the Plan shall supersede any provision of this Section regarding coordination of benefits.

EFFECT OF COBRA

The benefits of a plan covering the person on whose expense the claim is based either as a retired employee or as a person who has elected continuation of coverage (or as that person's dependent) will be determined after the benefits of any other plan covering such person as an employee other than as a retired employee or as a person who has elected continuation of coverage (or as that person's dependent).

COVERAGE FOR RETIRED EMPLOYEES - TEACHERS AND ADMINISTRATORS HEALTH PLAN

Coverage for retired teachers and administrators hired prior to 1987 with 20 or more years of service will be continued under this Plan as referenced in contractual agreement with the Reading Educational Association.

Coverage for retired teachers and administrators (and their dependents) with less than 20 years of service will be continued under this Plan if the retiree pays the appropriate cost to the employer.

Those retirees eligible to continue coverage on a contributory basis may select the medical benefits only, or the total health plan to include medical, dental vision and prescription drug benefits.

Premium payments must be made on a timely basis to avoid termination of coverage.

For Those Retired Teachers and Administrators Eligible for Medicare

- This Plan will be the secondary payer of benefits and Medicare will be the primary payer for benefits payable under both this Plan, and the Medicare coverage for

which you have enrolled. In such cases, this Plan will pay an amount which, when added to the Medicare payment, will not exceed 100% of the charge. However, payment under this Plan will never exceed the amount that would have been paid had the Plan been the primary payer.

- This Plan will be the primary payer for benefits eligible under the Plan, but excluded from coverage under Medicare.
- This Plan will make no payments for benefits covered by Medicare, but excluded from coverage under the Plan.

LIFE INSURANCE PLAN

Coverage for retired teachers and administrators with 20 or more years of service will be continued under this Plan at no cost to the retiree.

Coverage for retired teachers and administrators with less than 20 years of service, but with at least 10 years of service, will be continued under this Plan.

Retired teachers and administrators with less than 10 years of service will not be eligible to continue life insurance coverage under this Plan.

EMPLOYEES OTHER THAN TEACHERS AND ADMINISTRATION HEALTH PLAN

Coverage for retirees (and their dependents) with 10 or more years of service will be continued under this Plan if the retiree pays the appropriate cost to the employer.

Retirees with less than 10 years of service will not be eligible to continue health coverage under this Plan.

Those retirees eligible to continue coverage on a contributory basis may select the medical benefits only, or the total health plan to include medical, dental vision and prescription drug benefits.

For Those Retirees Eligible for Medicare

- This Plan will be the secondary payer of benefits and Medicare will be the primary payer for benefits eligible under both this Plan and Part A and Part B of Medicare. In such cases, this Plan will pay an amount which when added to the Medicare payment will not exceed 100% of the charge. However, payment under this Plan will never exceed the amount that would have been paid had the Plan been the primary payer.
- This Plan will be the primary payer for benefits eligible under the Plan, but excluded from coverage under Medicare.

- This Plan will make no payments for benefits covered by Medicare, but excluded from coverage under the Plan.

LIFE INSURANCE PLAN

Retirees other than teachers and administrators with 10 or more years of service are provided life insurance coverage under this Plan in accordance with their appropriate union negotiated contract.

GENERAL PROVISIONS AND INFORMATION

ADMINISTRATION OF PLAN

The Plan is administered through the personnel office of the employer. The employer has retained the services of an independent Plan Supervisor experienced in claims processing.

PLAN MODIFICATION AND AMENDMENT

The employer may modify or amend the Plan in accordance with the provisions of the collective bargaining agreement, and such amendments or modifications which affect covered participants will be communicated to participants.

PLAN TERMINATION

The employer may terminate the Plan at any time. Upon termination the rights of you and your dependents to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to participants.

SUBROGATION

If any payment is made under this Plan, the Plan Administrator will be subrogated to all the rights of recovery of the covered person to whom or for whose benefit the payment was made, to the extent of the amount paid. The covered person will execute and deliver instruments and papers and do whatever else is necessary to secure these rights and will do nothing to prejudice such rights.

ASSIGNMENT

The covered person's benefits may not be assigned, except by consent of the Employer, other than to suppliers of medical services.

INSPECTION OF PLAN

The Plan Document is on file at the employer's office at the address shown on the factual summary and can be inspected by you at any time during normal business hours.

RIGHTS AND PROTECTIONS

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain copies of all plan documents such as the form 5500, insurance contracts, collective bargaining agreements, updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- 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 or the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of 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 the preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date.

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Covered Persons and beneficiaries.

No one, including your employer 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. If a claim for a welfare benefit is denied 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 a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests information from the Plan and does not receive it within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the administrators. If anyone has a claim for benefits, which is denied or ignored, in whole or in part, they may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if anyone is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the persons sued to pay these costs and fees. If the individual loses, the court may order that person to pay these costs and fees, for example if it finds the claim is frivolous.

If there are any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about ERISA rights, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

LEGISLATIVE COMPLIANCE

All provisions of the Plan shall at all times be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ERISA and other applicable governmental laws, statutes, regulations, or rules promulgated by any governing unit having appropriate jurisdiction. The Plan Administrator shall administer the Plan accordingly, as well as complying with any changes to such statutes, regulations or rules affecting these provisions.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status - related factors, (physical or mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of coverage under the Plan, for determining the level of contribution to Plan funding, or to determine the level of benefits which will be made available to a person. All Plan

participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

No provision contained in this booklet nor any portion of the Plan shall give a Plan participant or entity acting on their behalf any right or cause of action, either at law or in equity against the Plan Administrator, the Third Party Administrator, the Plan Sponsor, or the Utilization Review Administrator for the acts of any Hospital where care is received, for the acts of any physician, or other provider from whom services are received and benefits are provided under this Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder. If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact the Plan Administrator.

Effective Date: This Notice of Privacy Practices became effective on April 14, 2004.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Payment: We may use or disclose your PHI to pay claims for services provided to you and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI when a provider (doctor, Hospital, clinic, etc.) requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations: We may use or disclose your PHI to support our business functions. These functions include, but are not limited to: medical care, quality assessment and improvement, stop-loss insurance underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about one of our health management programs; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Business Associates: We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide their services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Personal Representatives: We may disclose PHI to the patient or the patient's personal representative. A personal representative is a legal guardian, or a person designated by you to act on your behalf in making decisions related to your health care.

Public Health Activities: We may disclose PHI to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability.

Abuse or Neglect: If we believe you are the victim of abuse or neglect, we may disclose PHI to a government authority such as social services or protective services agency.

Health Oversight Activities: We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance.

Legal Proceedings: We may disclose PHI in the course of a judicial or administrative proceeding in response to legal order or other lawful process.

Law Enforcement Officials: We may disclose PHI to the police or other officials in compliance with a court order or subpoena.

Organ & Tissue Procurement: We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Coroners: We may disclose PHI to a medical examiner as authorized by law.

Specialized Government Functions: We may use and disclose PHI to units of the government with special functions such as the U.S. military or the U.S. Department of State.

Workers' Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Health & Safety: We may use and disclose PHI, if in good faith, we believe it is necessary to prevent or lessen a serious and imminent threat to the health & safety of a person or the public.

As Required by Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

To the Plan Sponsor: We may disclose your PHI to the plan sponsors of the group health plan for purposes of plan administration.

Others Involved in Your Care: We may disclose your PHI known to a family member, relative or close personal friend that you identify. Such a use will be based on how involved the person is in your care. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

YOUR RIGHTS

Right to Request a Restriction: You have the right to request a restriction on the PHI we use or disclose about you for claim payment or healthcare operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe that a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." A "designated record set" contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than claim payment or health care operations.

No accounting of disclosures is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of claim payment or health care operations, and, therefore, will not be subject to your right to an accounting.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice, even if you may have agreed to accept this Notice electronically.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by contacting the Privacy Officer.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may submit this complaint to:

Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Sponsor becomes aware.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

This booklet is not a contract. It explains in non-technical language the essential features of your Employee Benefit Program. Contact the Human Resources Department if there are any questions concerning coverage.

FACTS ABOUT THE PLAN

NAME OF PLAN	Reading School District Employee Benefit Plan
GROUP NUMBER	305
NAME AND ADDRESS OF EMPLOYER	Reading School District 800 Washington Street Reading, PA 19601
PLAN NUMBER	501 - Medical, Vision, and Life Insurance and Accidental Death Dismemberment and Loss of Sight Benefit Plan 502 - Prescription Drug Plan
TYPE OF PLAN	Self-Funded-Medical, Vision, and Prescription Drug Benefit Plan
TYPE OF ADMINISTRATION	Self-Administered
PLAN ADMINISTRATOR	Reading School District 800 Washington Street Reading, PA 19601 (610) 371-5665
PLAN SUPERVISOR	Medical and Vision Plan The Loomis Company 850 N. Park Road P.O. Box 7011 Wyomissing, PA 19610-6011
AGENT FOR LEGAL PROCESS	Service of legal process may be made upon the Plan Administrator.
PLAN YEAR END	June 30th
SOURCE OF PLAN CONTRIBUTIONS	The cost of your coverage and coverage for your dependents under the Plan is paid in full by the employees and employer.

It is the policy of the Reading School District not to discriminate on the basis of race, color, religion, national origin, sex, and handicap in its activities, programs, or employment practices as required by Title VI, Title IX, and Section 504.

The Reading School District also affirms that national origin, minority persons who lack English language skills can participate in all education programs, services, and activities and that reasonable accommodations will be made for handicapped persons.

For information regarding Civil Rights, grievance procedures, services, activities and facilities that are accessible to and usable by handicapped persons, contact:

HR Director

Reading School District, Administration Building,
800 Washington Street, Reading, PA 19601-3691

Telephone: (610) 371-5684

Or write to the Director of the Office For Civil Rights,
Department of Health and Human Services,
Washington, D.C.

La norma del Distrito Escolar de Reading es no discriminar en base de raza, color, religi6n, nacionalidad, sexo, impedimentos en actividades, programas o prdcticas de empleo, como es requerido por el Titulo VI, Tftulo IX y la Secci6n 504.

El Distrito Escolar de Reading tambi6n afirma que personas de origen minodtado que no sepan ingl6s pueden participar en todos los programas educativos, servicios y actividades, y que se hardn arreglos razonables para personas con impedimentos.

Para informaci6n sobre Derechos Civiles, procedimientos de quejas, servicios, actividades y facilidades que estan accesibles y disponibles para personas con impedimentos, llame a:

HR Director

Distrito Escolar de Reading, Edificio de Administraci6n
800 Washington St., Reading, PA 19601-3691

Tel6fono: (610) 371-5684

O escdba al Director de la Oficina de Derechos Civiles,
Departamento de Salud y Servicios Humanos, Washington, D.C.