

**HARRISON COUNTY**

**EMPLOYEE BENEFIT PLAN**

**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION**

EFFECTIVE: January 1, 2008

**REVISED: January 1, 2012**

**CONTRACT ADMINISTRATOR:**

Boon-Chapman Benefit Administrators, Inc.

**NOTICE TO ENROLLEES  
OF THE HARRISON COUNTY EMPLOYEE BENEFIT PLAN**

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. Harrison County has elected to exempt the Harrison County Employee Benefit Plan from 1 through 3 of the following requirements:

1. Standards relating to benefits for mothers and newborns. Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.
2. Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.
3. Coverage of dependent students on medically necessary leave of absence. Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary education institution.

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## ADOPTION OF THE PLAN DOCUMENT

### **Adoption**

The Plan Sponsor hereby adopts this Plan Document and Summary Plan Description (the "Plan Document") as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document is a restatement of any prior plan document, with benefit changes, and is effective on January 1, 2012.

### **Purpose of the Plan**

The purpose of the Plan is to provide certain benefits for Eligible Employees of the Employer and their Eligible Dependents. The benefits provided by the Plan include:

#### HEALTH CARE COVERAGES

Medical Coverage (Hospital, Physician Services, etc.)  
Prescription Drug Card

### **Intent to Comply with ERISA**

It is intended that this Plan Document will serve to describe the nature, funding, and benefits of the Plan. It is also intended that the Plan shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). If any portion of the Plan now or in the future conflicts with ERISA or any other applicable law or regulation, it shall be deemed to automatically be amended to comply with such law. In the event that any law, regulation or order or judgment of any court of competent jurisdiction shall cause the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

### **Acceptance of the Plan Document**

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed, effective as of January 1, 2012.

### **HARRISON COUNTY**

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

## ADMINISTRATIVE INFORMATION

Name of Plan: Harrison County  
Employee Benefit Plan

Plan Sponsor:  
Address: Harrison County  
200 W. Houston, Room 328  
Marshall, TX 75670

Business Phone Number: 903-923-4018

Plan Sponsor ID Number (EIN): 75-6000988

Plan Number: 501

Plan Year: January 1

Plan Benefits: Medical  
Prescription Drug Card

Plan Administrator (Named Fiduciary):  
Address: Harrison County  
200 W. Houston, Room 328  
Marshall, TX 75670

Business Phone Number: 903-923-4018

Designated Legal Agent:  
Address: Harrison County  
200 W. Houston, Room 328  
Marshall, TX 75670

(Legal process may also be served upon the Plan Administrator.)

Participating Employers: Harrison County

Contract Administrator: Boon-Chapman Benefit Administrators, Inc.

Street Address: 12301 Research Blvd., Suite 400  
Austin, Texas 78759

Mailing Address: P.O. Box 9201  
Austin, Texas 78766

Phone: (512) 454-2681 / (800) 252-9653

FAX: (512) 459-1552

## SCHEDULE OF MEDICAL BENEFITS

**Annual Deductibles:**

PPO: \$1,250 Individual  
           \$3,750 Family  
 Non-PPO: \$3,000 Individual  
           \$6,000 Family

**Annual Plan Benefit:**

(Includes All Other Maximums)  
 \$1,250,000

**Annual Out of Pocket Maximums:**

(Excluding Deductible)  
 PPO: \$4,000 Individual  
           \$12,000 Family  
 Non-PPO: Unlimited

The Plan will pay benefits to Covered Persons for Covered Expenses as described herein in accordance with the Schedule of Benefits. The Plan provides maximum benefits to the Covered Persons when they:

receive services or treatment from a provider who is a member of Aetna Signature Administrators preferred provider organization; and

follow the procedures of the utilization management program described herein, which is administered by Capitol HealthCare Review, Inc. (CHR), dba Prime Dx, a utilization management organization.

If you have questions about participating providers or need help finding a participating provider, call Boon-Chapman at (800) 252-9653. A current list of PPO providers is available, without charge, through the Aetna website (located at [www.aetna.com/asa](http://www.aetna.com/asa)). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Resources Department.

If you have questions about the utilization management program, call Prime Dx at (512) 454-5112 in Austin or (800) 477-4625 outside Austin.

The Contract Administrator of the Plan is Boon-Chapman Benefit Administrators, Inc. If you have other questions about the Plan (including questions about claims, premiums, and eligibility), call (512) 454-2681 or (800) 252-9653.

The following schedule summarizes the medical benefits of the Plan. Please refer to the remainder of the document for additional Plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
<b>Chemical Dependency and Substance Abuse</b>			
PPO	Yes	70%	Lifetime benefit limited to two series of treatments.
Non-PPO	Yes	50%	
<b>Chiropractic Care</b>			
PPO	Yes	70%	15 visits per calendar year.
Non-PPO	Yes	50%	
<b>Home Health Care</b>			
PPO	Yes	70%	Calendar Year Maximum of 120 visits
Non-PPO	Yes	50%	
<b>Maternity Benefits</b>			
PPO	Yes	70%	Office visit copay does not apply.
Non-PPO	Yes	50%	
<b>Mental and Nervous</b>			
PPO	Yes	70%	Calendar Year Maximum benefit of 30 days inpatient treatment and 30 outpatient visits.
Non-PPO	Yes	50%	

<b>Outpatient Pre-Admission Testing</b>					
PPO	Yes	100%			Testing must be done within 7 days of a scheduled hospital confinement at the same hospital where such confinement is scheduled to occur.
Non-PPO	Yes	50%			
<b>Outpatient Surgery</b>					
PPO	Yes	70%			If performed in physician's office and office visit is billed, that co-pay will apply as well.
Non-PPO	Yes	50%			
<b>Physician Office Visits</b>					
Good Shepherd Family Health Center- Marshall aka Rural Health Clinic	No	100%			<b>All services performed at GS Family Health Center-Marshall by a Mid-Level PA and/or Nurse Practitioner (located at 805 Lindsey, Marshall, TX) for members age 2 and up are covered at 100%.</b>
PPO	No	\$30 co-pay			
Non-PPO	Yes	50%			
<b>Preventive and Wellness</b>					
PPO and Non-PPO	No	100%			
<b>Prescription Benefit—Retail (30 day supply)</b>					
Generic	\$10 Copay per Rx	100%			
Preferred Brand	\$35 Copay per Rx	100%			
Non-Preferred Brand	\$50 Copay per Rx	100%			
Specialty	\$85 Copay per Rx	100%			
<b>Mail Order (90-day supply)</b>					
Generic	\$20 Copay per Rx	100%			
Preferred Brand	\$70 Copay per Rx	100%			
Non-Preferred Brand	\$100 Copay per Rx	100%			
Specialty	\$85	100%			<b>Specialty Drugs are only available for 30 day supply</b>
<b>Second Surgical Opinion</b>					
PPO	Yes	70%			
Non-PPO	Yes	50%			
<b>Skilled Nursing or Convalescent Facility</b>					
PPO	Yes	70%			Limit of 120 Days of confinement during any one confinement convalescent facility confinement period.
Non-PPO	Yes	50%			
<b>TMJ Treatment</b>					
PPO	Yes	70%			\$1,000 Lifetime Maximum
Non-PPO	Yes	50%			
<b>All Other Covered Expenses</b>					
PPO	Yes	70%			
Non-PPO	Yes	50%			

**Deductible**

This is the amount of Covered Expenses you pay each Calendar Year before benefits are paid. There is a Calendar Year Deductible that applies to each Covered Person. In network and out of network deductibles do not cross apply.

**Family Deductible Limit**

If Covered Expenses incurred in a Calendar Year by you and your Dependents and applied against the separate Calendar Year Deductibles equals the Family Deductible Limit, you and your Dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that Calendar Year.

**Benefit Maximums**

The maximum payable for all eligible medical expenses for each covered person shall not exceed, in the aggregate, the maximum plan benefit shown above, which applies to all periods a person is covered under the plan. This Maximum Plan Benefit applies to all plans and plan options offered by the Employer. When a Covered Person meets the Maximum Plan Benefit under one plan option, it will be considered met for all plan options offered by the Employer (if more than one is offered). Any lesser maximum benefit amounts are also applicable to all periods a person is covered under the plan. Other maximums may apply to specific periods, conditions, or types or levels of care and are as specified.

**Plan Co-insurance**

Plan Co-insurance is the portion of Covered Expenses that the Plan will pay, excluding those Covered Expenses that a Covered Person must pay:

- as a Deductible;
- as Co-insurance;
- as Co-payment; or
- because of a benefit maximum.

If a Covered Person does not comply with the utilization management program, the benefit payment will be reduced to 50% of what was otherwise payable.

**Exceptions to Plan Co-insurance**  
(Does not apply to transplants.)

The 70% In-network Provider co-payment percentage will apply, with no reduction in benefits for use of an Out-of-Network Provider, under the following circumstances:

- i. For treatment rendered by “forced providers” as defined below, the In-Network level of benefits shall apply. “Forced Providers” are defined as providers for whom the Covered Person had no choice in selecting while using a PPO provider. This includes, but is not limited to situations such as: (a) the Covered Person uses a PPO hospital and the emergency room Physician or anesthesiologist is a Non-PPO provider, (b) the Covered Person uses a PPO Physician and the lab work is sent to a Non-PPO provider.
- ii. The In-Network level of benefits shall apply for treatment rendered by a Non-PPO provider as a result of Emergency Care (including ambulance service).
- iii. The In-Network level of benefits will apply for treatment rendered by an Out-of-Network provider as a result of a referral from an In-Network provider.

**Prescription Drug Program**

A Covered Person may receive benefits for covered prescription drug expenses through the prescription drug program, which allows him to present his prescription drug card at a participating pharmacy, and pay a Co-payment. Co-payments for the prescription drug card program will not apply to major medical Plan deductibles or out-of-pocket expenses. If prescription drugs are purchased without using the drug card, the reimbursement payable under the major medical plan will be subject to the Co-insurance schedule as listed above.

### **Out-of-Pocket Maximums**

Except as provided below, a Covered Person shall not be required to pay, in one Calendar Year, more than \$4,000 or \$12,000 for the family to PPO providers for his Covered Expenses. Once he has done so, the Plan will pay all of his Covered Expenses for the remainder of the Calendar Year.

These out-of-pocket maximums do not apply to any Covered Expenses a Covered Person or covered family must pay:

as a Deductible;

as Co-insurance because of failure to comply with the utilization management program or the utilization management program;

as Co-insurance for transplants out of network;

over maximum eligible charges (if applicable)

as a Co-payment; or

because of a benefit maximum.

### **Pre-existing Conditions**

The term "Pre-existing Condition" means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the three-month period prior to the first day of coverage under this Plan or, if earlier, the beginning of any applicable Waiting Period. However, Pregnancy does not constitute a Pre-existing Condition. Further, any enrollee under age 19, or any enrollee who has Creditable Coverage without a Significant Break in Coverage is not subject to the Pre-existing Condition exclusion.

Claims resulting from Pre-existing Conditions are excluded from coverage under the Plan for a period of 12 months (18 months in the case of a Late Enrollee), except that if the combination of the Covered Person's period of Creditable Coverage occurring since any Significant Break in Coverage and the period of time the person has been covered under the Plan equals or exceed 12 months (18 months in the case of a Late Enrollee), the Pre-existing Condition exclusion will no longer apply.

### **Proof of Creditable Coverage**

A Covered Person may prove Creditable Coverage by either of the following two methods:

First, the Covered Person may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

the date the certificate was issued;

the name of the group health plan that provided the coverage;

the name of the Employee or Dependent to whom the certificate applies;

the name, address, and telephone number of the plan administrator or issuer providing the certificate;

a telephone number for further information (if different);

either (a) a statement that the Employee or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or (b) the date any Waiting Period (and Affiliation Period, if applicable) began and the date Creditable Coverage began; and

the date Creditable Coverage ended, unless the certificate indicates that coverage is continuing as of the date of the certificate.

Second, if the Covered Person for any reason is unable to obtain a certificate from another plan he or she may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services.

This Plan will treat an Employee as having provided a certificate if that individual:

- attests to the period of Creditable Coverage;
- presents relevant corroborating evidence of some Creditable Coverage during the period; and
- cooperates with the Plan's efforts to verify his coverage.

This Plan will treat a Dependent as having provided a certificate if he:

- attests to the dependency and the period of that status; and
- cooperates with the Plan's efforts to verify his status.

A Covered Person will, within 30 days of the Covered Person's effective date under the Plan, provide the Plan with proof of Creditable Coverage the Covered Person has that occurred since any Significant Break in Coverage.

#### **Notice of Pre-Existing Condition Exclusion**

If, within a reasonable time after receiving the information about Creditable Coverage described above, the Plan Administrator determines that an exclusion for Pre-existing Conditions applies, it will notify the Employee or Dependent of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the Plan's appeals procedures and give the Employee or Dependent a reasonable opportunity to present additional evidence.

If this Plan later determines that an individual did not have the claimed Creditable Coverage, the Plan may change its initial determination. In that case, the individual will be notified of the reconsideration; however, until a final determination is reached, the Plan will act in accordance with its initial determination in favor of the Employee or Dependent for the purpose of approving medical services.

## PRESCRIPTION DRUG CARD PROGRAM

The prescription drug card can be used to purchase prescription drugs at participating pharmacies.

### Co-pays:

#### Retail—30 day supply

Generic	\$10
Preferred Brand Name	\$35
Non-Preferred Brand Name	\$50
Specialty	\$85

#### Mail Order—90 day supply

Generic	\$20
Preferred Brand Name	\$70
Non-Preferred Brand Name	\$100
Specialty	\$85 (30 day supply)

Co-pays apply to prescriptions purchased through a participating pharmacy or a mail order program. Co-pays for the prescription drug card program will not apply to major medical plan deductibles or out-of-pocket expenses. If prescription drugs are purchased without using the drug card, there are no benefits payable under the medical plan.

All acute care prescriptions purchased through a participating pharmacy will be subject to a 30-day supply. Maintenance drugs have a dispensing limit of a 90-day supply. A separate co-pay applies for each 30 day supply.

Maintenance prescriptions may also be purchased through a mail order program, and are limited to a 90-day supply. A separate co-pay applies for each 90-day supply.

See the section entitled "Covered Medical Expenses -- Prescription Drugs", for complete description of prescription drug provisions and limitations.

**Dispense As Written:** A physician **dispense as written** prescription will cost the participant the brand name copayment. Physicians who insist upon the use of a brand name drug for a multisource drug must write the words Brand Necessary on the face of the prescription. If a physician authorizes the use of a generic drug for a multisource drug, but the participant insists on the use of a brand name drug, then the participant must pay the difference between what the participating pharmacy will be paid for the multisource drug and the actual charge for the brand name drug.

The prescription drug card program will be shown on the Employee identification card. For a list of participating pharmacies, please contact your Employer's benefits department or Boon-Chapman Benefit Administrators, Inc. at (800)252-9653 or (512)454-2681. [A current list of participating pharmacies is available, without charge, through the prescription drug card vendor's website (located at [www.maxorplus.com](http://www.maxorplus.com)). [If you do not have access to a computer at your home, you may access this website at your place of employment.

**UTILIZATION MANAGEMENT PROGRAM**  
**Call (800) 477-4625 or (512) 454-5112**

The Plan's utilization management ("UM") program is designed to encourage Covered Persons to obtain quality medical care in a cost-effective manner. The Plan's UM company is PrimeDx. The UM company does not diagnose or treat medical conditions. You can contact PrimeDx by telephone, mail, or fax. PrimeDx's phone number is (512) 454-5112 or (800) 477-4625. PrimeDx's mailing address is P.O. Box 9201, Austin, Texas 78766, and PrimeDx's fax number is (512) 454-1624.

Each covered Employee should received an identification card that contains instructions concerning the UM program. It should be carried by the Employee at all times and shown to all health care providers. The UM program requires that a Covered Person call PrimeDx in certain instances described below. It is always the Covered Person's responsibility to ensure that the call is made in a timely manner; however, the Covered Person's family or health care provider can make the call.

**Urgent Care Claims**

The Plan does not require a Covered Person to call PrimeDx in an Urgent Care Situation. An "Urgent Care Situation" is a situation that would make a claim an Urgent Care Claim if preauthorization were required by the Plan. Consequently there are no Urgent Care Claims under the Plan. An "Urgent Care Claim" is any Pre-service Claim for medical care or treatment under a plan with respect to which a) the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or, b) in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A "Pre-service Claim" is a claim for a benefit under a plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

**Pre-Admission Review**

Except in an Urgent Care Situation, the Covered Person must call PrimeDx at least five days before a scheduled hospitalization. PrimeDx will review the Medical Necessity of the proposed admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits.

**Concurrent Care Review**

Except in an Urgent Care Situation, if a Covered Person needs to stay in the Hospital longer than originally authorized, the Covered Person must call PrimeDx with in three business days. The UM company will review the Medical Necessity of the request and notify the individual or the provider whether the additional stay is authorized as Medically Necessary. If the authorization for the additional stay is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits. In an Urgent Care Situation, the Covered Person must notify PrimeDx on the first business day after the additional stay begins.

**Urgent and Emergency Admission Review**

In an Urgent Care Situation a covered person must call PrimeDx on the first business day after being hospitalized. PrimeDx will review the medical necessity of the admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits.

**Lower Level Care Admission**

PrimeDx will review admission to skilled nursing facility, rehabilitation facility, long term acute care facility to determine whether they are medically necessary and advise the covered person or the health care provider of its decision.

## **Review of Outpatient Services**

Except in an Urgent Care Situation, the Covered Person must call PrimeDx at least three business days before any scheduled procedure listed below:

Physical Therapy.

### **Case Management**

PrimeDx will also provide case management services to those members with catastrophic illnesses, chronic diseases, acute episodes of illness, traumatic injuries or individuals requiring multiple healthcare services.

A Covered Person must call PrimeDx within 30 days of learning that she is pregnant. In addition, a Covered Person must call PrimeDx within five days of becoming a possible candidate for an organ transplant.

If PrimeDx determines, that an alternative plan of treatment or a fee negotiation for services will likely result in cost savings to the Employer, it will encourage the physician or covered person to use the alternative treatment plan or the services available at a discounted fee. If the physician or covered person chooses not to do so, PrimeDx's responsibilities with respect to alternative plan of treatment will be complete.

### **Second Opinion**

At any time during the UM process, PrimeDx may ask the Covered Person to obtain a second opinion about the Medical Necessity of a proposed Surgery, procedure or health care treatment. The Physician providing the second opinion will be chosen by PrimeDx. If the Covered Person does not obtain the second opinion, no benefits will be paid by the Plan.

### **Plan Administrator Utilization Management Discretion**

The Plan Administrator shall have the discretion to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of care.

### **Effect of Obtaining an Authorization**

**The authorization of admission, care or services does not guarantee the payment of benefits. Eligibility and payment of benefits are subject to all of the terms and provisions of the Plan.**

## **MEDICAL CARE COVERAGES ELIGIBLE MEDICAL EXPENSES**

Except as otherwise noted below or in the medical Schedule of Benefits, Covered Expenses are the Maximum Eligible Charges for services listed below that are Incurred by a Covered Person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. In general, services and supplies must be approved by a Physician and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy, or other covered health care conditions.

### **Abortion**

Covered Expenses are limited to abortions that eliminate a substantial danger to the mother's life, but expenses Incurred as a result of medical complications arising from an abortion are also covered.

### **Alcoholism**

### **Allergy Testing**

See Schedule of Benefits for possible limitations.

### **Ambulance**

Professional local ambulance service by a state-licensed ambulance company to the nearest Hospital in connection with care for a medical emergency or Accidental Injury.

### **Ambulatory Surgical Center/Licensed Surgical Facility**

### **Anesthesia**

The charges made for anesthetics and by a Physician or Nurse Anesthetist for the administration of anesthesia. If both an anesthetist and a Nurse Anesthetist are utilized, covered charges are limited to Maximum Eligible Charges of an anesthetist for the covered operative procedure.

### **Assistant Surgeon**

The Plan will cover charges by an assistant surgeon when Medically Necessary due to the nature of the procedure being performed. The Plan will allow up to twenty-five percent (25%) of the primary surgeon's Covered Expenses.

### **Birthing Centers**

### **Blood**

The charges for blood and blood plasma (if not replaced by or for the patient), including blood processing charges.

### **Casts, Splints, Trusses, and Surgical Dressings**

### **Chemotherapy**

### **Chiropractic Care**

Manipulation to correct such vertebral disorders as incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing. See Schedule of Benefits for possible limitations.

### **Cosmetic or Plastic Surgery**

Charges are covered if required to correct a physical or functional problem subject to the following:

If required due to injury; or

As reconstructive surgery:

due to or following surgery resulting from trauma, infection or other diseases of the involved part;  
as required by The Women's Health and Cancer Rights Act.

### **Dental Care**

treatment of fracture of facial bones;

excision of lesions of the mandibular joints, mouth, lips, or tongue;

incision of accessory sinuses or mouth salivary glands or ducts;

treatment of dislocation of the jaw;

extractions;

plastic reconstruction or repair of the mouth or lips necessary to correct or repair traumatic injury or congenital defect, which includes any appliances, orthodontia treatment, or other scheduled treatment plans to correct or repair such traumatic injury or congenital defect; or

treatment required because of Accidental Injury to natural teeth. Such expenses must be Incurred within six months of the date of the accident (unless otherwise required by applicable law).

### **Diabetic Training**

#### **Diagnostic Services**

Diagnostic laboratory and x-ray expenses, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by Physicians throughout the United States. See also "Pre-Admission Testing".

#### **Durable Medical Equipment**

Rental of Durable Medical Equipment (but not to exceed the purchase price) or purchase of such equipment, where only purchase is permitted, prescribed by a Physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of a Sickness or Accidental Injury. Purchase or rental of luxury medical equipment (e.g., motorized wheelchairs or other vehicles or bionic or computerized artificial limbs) is not covered when standard equipment is appropriate for the patient's condition.

#### **Home Health Care**

Covered Expenses are limited to those for services listed herein that are furnished by a Home Health Care Agency to a Covered Person who is under the care of a Physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending Physician, and the orders must be renewed at least every 30 days. The attending Physician must also certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan.

Covered Expenses for home health care visits are limited to those made by:

a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);

home health aides under supervision of a R.N.;

physical, occupational, and speech therapists; or

a licensed midwife.

Covered home health care expenses will also include medical supplies, drugs, and medicines prescribed by a Physician, laboratory services, and special meals prescribed by a Physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the Covered Person had remained in the Hospital.

#### **Home Infusion Therapy**

#### **Hospice**

Covered Expenses are limited to hospice care approved every thirty (30) days by the utilization management organization. In addition, Covered Expenses are limited to charges for the following services provided by a Hospice Care Program for the care of a Covered Person with a Physician-diagnosed life expectancy of 6 months or less:

nursing care by a licensed registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed vocational nurse (L.V.N.), or a public health nurse who is under the direct supervision of a licensed registered graduate nurse (R.N.);

medical services, supplies, and drugs; or

Physician's services.

In addition, bereavement counseling is a Covered Expense if provided by a Hospice Care Program to a Covered Person's spouse, children, or parents within three months of the death of a Covered Person who was in a Hospice Care Program at the time of death. See Schedule of Benefits for possible limitations.

### **Hospital Services**

Covered Expenses include:

daily room and board charges based on the Semi-private Room Charge;

private room charges will be covered if Medically Necessary by the patient highly susceptible to contracting another Illness by being in a semi-private room or patient is contagious; and

all other Medically Necessary services and supplies furnished by the Hospital, but not for private-duty nursing care.

See Schedule of Benefits for pre-certification requirements and preferred provider arrangements that may determine the level of benefits.

Hospital audits by an independent auditing firm will be considered Covered Expenses under the Plan.

### **Laboratory Tests**

#### **Mastectomy Reconstruction**

Covered Expenses include the following in connection with a covered mastectomy:

reconstruction of the breast on which the mastectomy has been performed;

Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and physical complications of all stages of mastectomy, including lymphedemas.

#### **Mental Health Care**

See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.

#### **Midwife**

Services of a registered nurse midwife.

#### **Multiple Surgical Procedures**

Multiple surgical procedure allowances are specified below:

Primary procedure, bilateral primary procedure, or add-on to primary procedure: maximum eligible charge or negotiated fee;

Secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Bilateral secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Add-on to secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Separate (incidental) procedure in same operative area as any of the above: not covered;

Separate operative area: maximum eligible charge or negotiated fee.

### **Newborn Care**

Hospital and Physician services rendered during the birth confinement to a covered newborn child (including such charges of a well newborn).

### **Nursing Services**

The charges made by a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) for private-duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type and when performed in the Covered Person's home. See Schedule of Benefits for possible limitations.

### **Outpatient Surgery**

Covered Expenses incurred in connection with any surgical procedure that is performed on an Outpatient basis in a Hospital, Ambulatory Surgical Center, or Physician's office. Charges must be Incurred on the same day as the Surgery, except that tests required by the Hospital because of the Surgery will be covered if they are Incurred within seven days prior to the Surgery.

### **Oxygen**

Oxygen, and services and supplies for the administration of oxygen.

### **Pathology**

### **Physical Therapy**

The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

### **Physician Services**

The charges made by a Physician for medical and surgical treatment.

### **Pre-admission Testing**

The charges for diagnostic tests performed on an Outpatient basis prior to a scheduled Hospital admission when the tests are performed within seven days before admission to the Hospital and the patient is subsequently admitted to the Hospital.

### **Preferred Provider Organization**

If a preferred provider organization (PPO) is shown in the Schedule of Benefits, then the PPO negotiated fees with healthcare providers will be considered the Maximum Eligible charge.

### **Pregnancy**

Pregnancy expenses of a covered Employee or covered Spouse are covered to the same extent as any Sickness.

Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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).

### **Prescription Drugs**

Covered prescription drug expenses are limited to those for:

injectable drugs which have been approved by the FDA for the particular diagnosis for which being treated;

prescription legend drugs (i.e., any medicinal substance whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription");

FDA approved and specific to the diagnosis;  
contraceptives devices, including oral and injectable;  
diabetic supplies;  
compound medications, of which at least one ingredient is a prescription legend drug;  
prescribed prenatal legend vitamins;  
vitamins with fluoride;  
any other drugs that under the applicable state or federal law may be dispensed only upon the written prescription of a Physician; and  
injectable insulin, including disposable insulin needles or syringes, or other injectable drugs which have been approved by the FDA for the particular diagnosis for which being treated;  
Nicorette or any other drug containing nicotine or other smoking-deterrent medications (one prescription per lifetime);  
OTC PPI Medications (for gastric acid), with a written prescription, are available at retail

and do not include those expenses for:

tretinoin, all dosage forms (e.g. Retin-A), for individuals 26 years of age or older;  
over-the-counter (OTC) drugs, with the exception of OTC PPI Medications (for gastric acid) which are available at retail;  
non-insulin syringes;  
injectables, other than those listed  
biological serums (immunological vaccines);  
medical devices/supplies;  
erectile dysfunction/organic impotence drugs;  
diagnostic agents (test kits);  
RU486 (Mifepristone);  
Hair growth stimulants;  
Growth hormones;  
Vitamins, other than those listed;  
anorectics (drugs used for the purpose of weight control);  
Rogaine (minoxidil);  
dietary supplements;  
fluoride supplements;  
non-legend drugs other than insulin;  
charges for the administration or injection of any drug;

therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances regardless of their intended use, except those listed above;

prescriptions that a Covered Person is entitled to receive without charge under any workers' compensation law;

drugs labeled: "Caution — limited by federal law to investigational use" or experimental drugs, even if a charge is made to the Covered Person;

immunization agents, biological sera, blood, or blood plasma;

medication that is to be taken by or administered to an individual, in whole or part, while he is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

drug charges exceeding the cost for the same drug in conventional packaging;

any quantity of drugs or medicines dispensed that exceeds a 34-day supply or 100-unit dose, whichever is greater, when taken in accordance with the direction of the prescriber; unless provided through a mail order program specified in the Schedule of Benefits.

infertility medications; and

any prescription refilled before 75% of the supply is used or in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.

### **Preventive and Wellness**

The Plan will pay the percentage outlined in the Schedule of Benefits for eligible expenses incurred in connection with the following Preventive and Wellness care. Expenses will be subject to the Individual Annual Medical Deductible and Co-Payment provisions of the Plan if 1) the claim indicates that an illness or injury is present, if 2) the expenses are in excess of the maximum amount shown in the Schedule of Benefits and an illness or injury is present. Otherwise, charges in excess of the maximum amount shown above are not covered.

1. For Covered Employees and Dependents, eligible examinations and services may include, but are not limited to:
  - a. Routine physical examination, including related diagnostic tests and lab expenses performed during the same visit;
  - b. Routine gynecological (pelvic exam/pap smear);
  - c. Prostate screening (PSA) test;
  - d. Hemoccult (colon) test;
  - e. Mammography examinations (whether or not routine), for breast cancer screening and diagnosis as follows:
    - i. One baseline mammogram for women age 35 and over.

### **Prosthetic Appliances**

Covered Expenses are limited to those for:

an initial temporary and permanent Prosthesis required to replace natural body parts lost or removed;

an initial Prosthesis required to aid the function of body organs; and

a replacement Prosthesis necessitated by the growth of a child.

### **Radiation Therapy**

Radium and radioactive isotope therapy.

### **Radiology and X-rays**

### **Respiratory Therapy**

The charges for the professional services of a licensed respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

### **Second Surgical Opinion**

The Maximum Eligible Charges of a Physician for a second (or third) surgical opinion consultation and related diagnostic work, when recommended by the utilization management organization.

### **Skilled Nursing Facility**

Covered Expenses are limited to Skilled Nursing Facility room and board and services when the confinement is approved and reviewed every 30 days by the utilization management organization.

### **Sleep Disorders Treatment**

Covered Expenses are limited to treatment of apnea and narcolepsy.

### **Speech Therapy**

Services by a qualified speech therapist when specifically prescribed by and under the direct supervision of a Physician, to restore or rehabilitate any speech loss or impairment caused by Accidental Injury or Sickness except a mental, emotional, or nervous disorder. In the case of a congenital defect that can be corrected or improved with Surgery, expenses will be considered only if incurred after Surgery for the defect.

### **Sterilization Procedures**

Sterilization procedures for Employees and spouses ONLY.

### **Temporomandibular Joint Dysfunction (TMJ)**

See the Schedule of Benefits for possible limitations.

### **Transplants**

Services and supplies in connection with transplant procedures, subject to the following conditions.

Case management is required by the utilization management organization for all services.

A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialty training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

If the donor is covered under this Plan, Covered Expenses Incurred by the donor will be considered for benefits.

If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by a donor who is not ordinarily covered under this Plan according to participant eligibility requirements will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Plan Benefit still available to the recipient.

If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person will be treated separately for each person.

The Maximum Eligible Charge of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a Covered Expense.

### **Urgent Care Facilities**

A freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board-certified Physician, a licensed registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, and x-ray and laboratory equipment and a life support system. An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made a part of, a regular Hospital.

**Vision Care**

Covered Expenses are limited to the initial purchase of glasses or contact lenses following cataract Surgery covered by the Plan.

**Wellness Benefit**

Charges up to the limitation shown in the Schedule of Benefits per Calendar Year per Covered Person. One each of the following examinations are covered per calendar year, unless more frequently recommended by the attending Physician:

Diagnostic x-ray and lab expenses;

Routine physical examination, including related diagnostic tests performed during the same visit;

Routine gynecological (pelvic exam/pap smear);

Prostate screening (PSA) test;

Hemoccult (colon) test;

Mammography examinations (whether or not routine), for breast cancer screening and diagnosis, as follows:

One baseline mammogram for women age 35 and older.

## MEDICAL LIMITATIONS AND EXCLUSIONS

In addition to the General Health Care Coverage Exclusions, the Plan will not provide benefits for any of the services and supplies listed in this section. Further, the Plan only covers those expenses specifically described as covered in the preceding section. Consequently, there may be expenses in addition to those listed below which are not covered by the Plan.

### **Abortion**

Elective abortion unless the mother's life would be endangered if the Pregnancy were allowed to continue to term; however the following abortions will be considered payable if considered legal in the state in which they are performed: to preserve the life of the Covered Person; as a result of complications of pregnancy; and as a result of incest or rape. Complications arising out of an abortion, however, are covered as any other Sickness.

### **Acupuncture**

### **Air Purification Units**

Air conditioners, air-purification units, humidifiers, or electric heating units.

### **Assistant Surgeon**

Charges made by an assistant surgeon in excess of 25 percent of the surgeon's allowable charge or for charges made by a co-surgeon in excess of the maximum eligible charge. For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to Co-payment or Deductible amounts.

### **Biofeedback**

### **Blood**

Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.

### **Breast Implants**

Except as provided under the Mastectomy Reconstruction provision in the Covered Medical Expenses section, breast implants placed for cosmetic reasons, removal, reconstruction or re-implantation due to complications are not covered. There will be coverage if there is documentation of leakage of a silicone implant and/or a positive silicone antibody study for removal of implants only.

### **Cosmetic Surgery**

Services or supplies related to cosmetic surgery, except as shown as an Eligible Medical Expense.

### **Custodial Care**

Care or confinement primarily for the purpose of meeting personal needs that could be rendered at home or by persons without professional skills or training.

### **Dental Care**

Care or treatment of or to the teeth, alveolar processes, or gingival tissue or for malocclusion is not covered. Replacement of teeth that were broken due to a chewing injury is not covered.

### **Diagnostic Hospital Admissions**

Hospital confinement for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

### **Exercise Equipment**

Exercising equipment, vibratory equipment, or swimming or therapy pools.

### **Foot Care (routine)**

Expenses Incurred for the non-surgical treatment of the feet, treatment of corns, calluses, or toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Expenses Incurred for orthopedic shoes (except when permanently attached to braces) and other supportive appliances for the feet.

**Hair Transplants**

**Hearing Aids or Related Examinations**

**Hypnosis**

**Impregnation**

Artificial insemination, in-vitro fertilization, or any other type of artificial impregnation procedure.

**Infertility**

Charges related to or in connection with fertility studies, sterility studies, or procedures to restore or enhance fertility.

**Nicotine Addiction**

Charges related to treatment of nicotine addiction, with the exception of one prescription benefit per lifetime.

**Non-Prescriptive Contraceptives**

**Obesity**

See "Weight Control."

**Occupational Therapy**

Occupational therapy (except during Hospital confinement or as included in home health care services) or vocational, educational, recreational, art, dance, or music therapy.

**Penile Prosthesis Implantation**

**Personal Comfort or Convenience Items**

Services or supplies provided for personal comfort including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets, mattress covers, wigs, non-prescription drugs and medicines, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments for such equipment.

**Pre-existing Conditions**

See the Schedule of Benefits for details.

**Pregnancy**

Charges related to a surrogate mother are not covered.

**Prescription Drugs - Outpatient**

Outpatient prescription drug coverage is provided only under the terms of the "Prescription Drugs" section in Medical Care Coverages, Covered Expenses.

**Psychiatric Testing, Counseling, or Therapy**

Except as may be specifically provided herein, the Plan does not cover psychiatric or psychological testing or evaluation (unless specifically related to the treatment of a psychiatric condition), hypnotherapy, or marriage or family counseling; treatment of learning disorders, behavioral problems, mental retardation, or autism of childhood; vocational testing, evaluation, or counseling; or therapy or counseling for sexual dysfunctions or inadequacies.

**Research**

Treatments, services or supplies that are educational or provided primarily for research; or treatments, procedures, devices, drugs or medicines or other expenses relating to transplants of non-human organs.

**Self-Procured Services**

Charges for services rendered to a Covered Person who is not under the regular care of a Physician or charges for services, supplies, or treatment, including any period of Hospital confinement, not recommended, approved, and certified as Medically Necessary and reasonable by a Physician.

**Sex-Change Procedures**

Sex-change counseling or treatment, services incident to sex-change Surgery, or any resulting complications.

**Skilled Nursing/Convalescent Facility**

Services are not covered for those expenses incurred in connection with mental or nervous disorders, alcoholism or drug abuse.

**Sterilization Reversal Surgery**

Expenses Incurred for the reconstruction (reversal) of a previous sterilization procedure.

**Telephone Services**

Charges for services rendered over the telephone; however, this exclusion will not apply to charges for transtelephonic transmission accompanying the medically necessary use of monitors required for the management of a medical condition, such as but not limited to the Holter monitor for cardiac arrhythmias.

**Therapy Services**

Services rendered for remedial reading or recreational and visual therapy; behavior modification therapy and pain rehabilitation control.

**Transportation Devices**

Rental or purchase of transportation devices (i.e. vans, cars, airplanes, etc.); or travel, even though prescribed by a Physician.

**Vision Care**

Eye examinations for the purpose of prescribing corrective lenses, eye glasses, or contact lenses or the fitting thereof.

The Plan does not cover vision procedures whose purpose is the correction of refractive error, such as radial keratotomy.

**Weekend Admissions**

Hospital room and board charges incurred on the first Friday, Saturday or Sunday during a hospital inpatient admission beginning on any of those days except for:

1. An emergency admission for an acute illness;
2. A maternity admission; or
3. An admission in which a surgical procedure is performed or Medically Necessary treatment is received within twenty-four (24) hours following the patient's admission to the hospital.

**Weight Control**

Services or supplies for obesity, weight reduction, or dietary control.

**Wigs and Wig Maintenance**

## GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all benefits provided under this Plan, and no benefits shall be payable for:

### **Cosmetic Services**

Any Surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except when:

necessary due to a non-occupational Accidental Injury;

necessary for correction of post-surgical deformity.

### **Court-Ordered Confinement**

Any confinement of a Covered Person in a public or private institution as the result of a court order.

### **Criminal Activities**

Any Injury or any complication thereof occurring during the Covered Person's commission of a felony offense or in the immediate flight therefrom.

### **Drugs in Testing Phases**

Medicines or drugs that are in the Food and Drug Administration phases I or II testing. Medicines or drugs in phase III testing may be covered if specifically approved by the process of large case management by Prime Dx.

### **Education or Training Program**

Services performed by a Physician or other provider enrolled in an education or training program when such services are related to the program.

### **Excess Charges**

Charges in excess of the Maximum Eligible Charges for services or supplies provided.

### **Forms Completion**

Charges for the completion of claim forms or for providing supplemental information.

### **Government-Operated Facilities**

The Plan does not cover loss caused by or resulting from confinement or treatment for which the Covered Person is not legally obligated to pay, such as in any government hospital. However, the U.S. government has a right to recover or collect benefits for any care or services Incurred by a Covered Person as a result of a non-service-connected Injury or Illness. The U.S. government may recover or collect to the extent that the Covered Person would be eligible to receive benefits under this Plan if such care or services had not been furnished by a department or agency of the United States.

### **Immediate Family or Resident Care**

Any service rendered to a Covered Person by a member of the Covered Person's Immediate Family or anyone who customarily lives in the Covered Person's household.

### **Incorrect and/or inappropriate coding and/or billing practices**

Any portion of a claim that the administrator determines to be incorrectly or inappropriately billed by a physician, health professional, facility or hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period or take place on the same day, duplicate services, and inappropriate modifier use. The determination that a service was incorrectly or inappropriately billed is based on documentation from the Centers for Medicare and Medicaid Services, The National Correct coding Initiative and/or other coding vendors or industry regulatory agencies.

### **Investigative, Experimental, or Research Procedures**

See definition of "Medically Necessary"

### **Late-Filed Claims**

Claims that are not filed with the Contract Administrator for handling within 12 months after the date the expenses are Incurred.

**Military Service**

Charges for treatment of any Injury sustained or Illness contracted while in the military service of any country.

**Missed Appointments**

Expenses incurred for failure to keep a scheduled appointment.

**No Charge/No Legal Requirement to Pay**

Services for which no charge is made or for which a Covered Person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this Plan.

**Other Coverage**

Health care services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

**Outside United States**

Charges Incurred outside of the United States if the Covered Person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

**Prior Coverage**

Services or supplies for which the Covered Person is eligible for benefits under the plan that this Plan replaces.

**Prior to or After Coverage**

Services or supplies that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

**Self-Inflicted Injury**

Any expenses resulting from voluntary or involuntary self-inflicted Injury or voluntary or involuntary attempted self-destruction that occurred while the Covered Person was sane or insane, regardless of whether the Covered Person was aware of or in control of his actions. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

**Travel**

Unless approved by the utilization management organization.

**Veteran's Hospital**

See "Government-Operated Facilities."

**War**

Medical or dental conditions resulting from insurrection, war (declared or undeclared), or any act of war and any complications there from, or service in the armed forces of any country.

**Work-Related Injury or Sickness**

Any injury or sickness that is caused by, or connected in any way to, employment of the covered person. (This includes self employment or employment by others. It applies whether or not workers' compensation or similar law covers the expenses incurred.)

## COORDINATION OF BENEFITS

All benefits provided under the health care coverages of this Plan are subject to the following provisions and limitations, unless specifically stated otherwise.

### Definitions

As used in this provision, the following terms shall have the meanings indicated:

#### Other Plan

"Other Plans" include benefits, services, or treatment provided by:

group, blanket, or franchise insurance coverage;

group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);

group Blue Cross and Blue Shield coverage;

group automobile insurance;

individual auto insurance based upon the principles of no-fault coverage;

any coverage under labor-management trustee plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or

any group coverage sponsored by or provided through a school or other educational institution.

#### This Plan

"This Plan" shall refer to the health care coverages of this Plan.

#### Allowable Expense

"Allowable Expense" shall mean any Maximum Eligible Charge Incurred while the person for whom claim is made is covered under This Plan, at least a part of which is covered under any Other Plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

#### Claim Determination Period

"Claim Determination Period" shall mean a period that commences each January 1 and ends at 12 o'clock midnight on the next December 31, or that portion of such period during which the Claimant has been covered under This Plan.

### Effect on Benefits Under This Plan

#### When Other Plan Does Not Contain a Coordination of Benefits Provision

As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such Allowable Expenses under This Plan and all Other Plans shall not exceed the total of such Allowable Expenses. Benefits payable under the Other Plans include benefits that would have been payable had claim been duly made for them.

#### When Other Plan Contains a Coordination of Benefits Provision

If the Other Plan insuring the person covered by This Plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of This Plan and would, according to its rules and the order of benefit rules below, determine its benefits after the benefits of This Plan have been determined, then the benefits of such Other Plan will not be considered for the purpose of determining the benefits due under This Plan.

If, according to the Other Plan's rules and the order of benefit rules below, This Plan is to determine its benefits after the Other Plan's benefits are determined, then the sum of all the benefits payable for Allowable Expenses under This Plan and all Other Plans shall not exceed the total of such Allowable Expenses Incurred during the Claim Determination Period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization management-type of program, This Plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, This Plan will base its coordination on the amounts that would have been paid if PPO or HMO providers had been used.

**When This Plan's PPO negotiates a specific COB provision with a particular participating provider**

The Plan's normal COB provision will be superceded by the PPO's COB provision.

**Order of Benefit Determination**

The rules establishing the order of benefit determination are:

the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent;

the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee;

the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail;

when Claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:

(i) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or

(ii) if the Other Plan does not have the rule described above under (i), and if, as a result, the plans do not agree on the order of benefits, the rule of the Other Plan will determine the order of benefits;

when Claimant is a dependent child whose father and mother are legally separated or divorced:

the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;

the plan of the spouse of the parent with custody will be determined second; and

the plan of the parent not having custody of the child will be determined third; or

if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

Notwithstanding the foregoing, This Plan is always secondary to no-fault auto insurance coverages.

If none of the above rules establishes an order of benefit determination, the benefits of the plan that has covered the Claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this

provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

**Right to Receive and Release Necessary Information**

For the purpose of enforcing or determining the applicability of the terms of this provision of This Plan or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Contract Administrator such information as may be necessary to enforce this provision.

**Special Provisions with Respect to Medicare**

In accordance with the Medicare Secondary Payor Act, as amended, an active Employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under This Plan. If such person elects coverage under This Plan, the benefits of This Plan shall generally be determined before any benefits provided by Medicare. However, whenever This Plan may lawfully assume a secondary position, it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When This Plan may lawfully assume a secondary position and an Employee or Dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under This Plan. An Employee or Dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner.

## **SUBROGATION AND REIMBURSEMENT**

### **Benefits Subject to This Provision**

This provision shall apply to all benefits provided under any section of this Plan.

### **When This Provision Applies**

A Covered Person may incur medical or other charges related to Injuries or Sickness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Sickness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

### **The Covered Person must:**

Execute and deliver a Subrogation and Reimbursement Agreement;

Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise);

Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

### **Amount Subject to Subrogation or Reimbursement**

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in

full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

**Another Party**

Another Party shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

Another Party shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

**Recovery**

Recovery shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

**Subrogation**

Subrogation shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

**Reimbursement**

Reimbursement shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

**When a Covered Person Retains an Attorney**

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

**When the Covered Person is a Minor or is Deceased**

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

**When a Covered Person Does Not Comply**

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

## ELIGIBILITY AND EFFECTIVE DATES

### **Eligibility Requirements — Employees**

"Employee" shall mean a person who is a regular full-time employee of the Employer, regularly scheduled to work for the Employer in an employer-employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered "full-time." For purposes of the Plan, seasonal, temporary and leased employees will not be deemed to be "Employees."

In order to be an "Eligible Employee," so that he is eligible to participate in the health care coverages of the Plan, an Employee must complete a Waiting Period of 90 days of continuous service. An Employee shall be deemed to be in full-time employment if he is absent from work due to a health factor. However, in order to be eligible to participate in the Plan, the Employee must begin work for his Employer. If he is unable to do so, then his coverage will become effective on such later date when he actually begins work.

### **Effective Date — Employees**

Eligible Employees who are employed and enrolled on the effective date of the Plan and who were validly covered under the Employer's plan of health care coverage that this Plan replaces will be covered on this Plan's effective date. All other Employees will be effective as set forth above.

If an Employee fails to enroll within 31 days of completion of the Waiting Period, the Employee's coverage will be effective only if enrolled under the special enrollment provision or if enrolled during an open enrollment.

### **Retiree Eligibility**

Retired Employees, who are former Employees retired from the Employer, and who are eligible to qualify as a Retiree as defined by the Texas County and District Retirement System, are also considered as eligible. Such Retired Employees shall be eligible for medical coverage under "retired employee status".

### **Contribution Basis for Retired Employees**

Coverage for Retired Employees is Contributory for Medical.

### **Provisions for Re-hired Employees**

An Employee previously covered under this Plan whose coverage ceases due to voluntary termination of employment, and who is re-hired within 31 days and becomes an eligible Employee shall become eligible for coverage again, for himself and any previously covered eligible Dependents, in accordance with the following provisions:

- A. Such persons shall be reinstated on the date re-hired, as if no interruption in coverage occurred, not subject to a new waiting period, but subject to all other provisions required of a new Employee, including a new Calendar Year Deductible, a new Out-of-Pocket Maximum, within that calendar year, and any applicable provisions of the "Pre-Existing Conditions and Creditable Coverage" articles of the plan. Any expenses incurred and applied toward the Plan's specified maximums prior to cessation of coverage will apply when coverage resumes.

### **Eligibility Requirements — Dependents**

If an Employee is covered by the Plan, the Employee's Eligible Dependents can also be covered. An "Eligible Dependent" is:

a spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage;

any natural child under the age of 26 (including any legally adopted child or a child placed for adoption with Employee; a stepchild under the age of 26; a foster child or grandchild under age 26 if obtained by legal custody).

An "Eligible Dependent" does not include:

any natural child as defined above who is eligible to enroll in an employer-sponsored health plan offered to them by the child's employer (unless it is the group health plan of the employee) or by the child's spouse's employer;

- any person who is eligible as an Employee under the Plan;
- any person who is covered as a Dependent of another Employee under the Plan.
- any person who is on active duty in a military service.

**Qualified Medical Child Support Orders**

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (QMCSO) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

**Alternate Recipient** shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

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

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

**National Medical Support Notice (NMSN)** shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

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

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

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

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

Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

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

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

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

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

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - (a) Whether the child is covered under the Plan; and
  - (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

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

#### **Contribution Basis for Dependents of Active Employees**

Contribution basis for dependents of active employees is Contributory.

#### **Contribution Basis for Dependents of Retired Employees**

Coverage for Dependents of Retired Employees is Contributory.

#### **Effective Date — Dependents**

Subject to the Plan’s special enrollment provisions, an Eligible Dependent will be covered beginning with the later of the following dates, provided the Employee makes written application for coverage for such Dependent in a form

furnished by the Plan Administrator or Contract Administrator for that purpose within 30 days of Dependent's initial eligibility and the Employee has agreed to pay any required contribution for such coverage:

the date the Employee's coverage begins, provided the Employee enrolled all Eligible Dependents on or before Employee's effective date; or

the date of enrollment, if the Employee enrolls all Eligible Dependents within 30 days of Employee's eligibility date.

A Dependent's coverage will not become effective prior to the Employee's effective date. Further, any change in a Dependent's coverage will not become effective until the change in the Employee's coverage also has become effective.

#### **Continuation of Health Coverage for Dependents of Deceased Employees**

An eligible surviving spouse may be entitled to health benefits if the Employee's death is caused by a job related incident as defined by Workers Compensation. Benefits for the spouse will be continued until the earlier of:

- A. Spouse remarries;
- B. Becomes eligible for group health insurance benefits through employment;
- C. Becomes eligible for Medicare benefits; or
- D. The date of discontinuance of premium payments.

An eligible surviving child (Note: Dependent Child must meet the definition of dependent as state in the Plan Document) may be entitled to health benefits until the earlier of:

- A. Becomes eligible for group health insurance through employment;
- B. Becomes eligible for Medicare benefits; or
- C. The date of discontinuance of premium payments.

**NOTE: The Employee must be covered for health benefits under the plan at the time of death for benefits to be extended to eligible surviving dependents. The dependents do not have to be on the deceased employees health benefits at the time of the employees death in order to be eligible for coverage.**

#### **ELIGIBILITY**

The eligible survivor will be effective on the date of written application subject to the Pre-existing Conditions and Creditable Coverage articles of this Plan. Coverage must be requested within 90 days of death of employee or the date that they first become eligible for continuation coverage under this provision. However, should an eligible survivor have COBRA benefits available under another plan of benefits, the COBRA benefits will have to be exhausted before the survivor is eligible for benefits under this Plan. Once COBRA benefits under other coverage have been exhausted, an eligible survivor may apply for coverage under this Plan.

If an eligible surviving spouse forfeits benefits under this Plan for any reason other than the two stated below, they will be ineligible to re-enter the plan should they regain eligibility.

- A. Becomes eligible for group health insurance through employment; or
- B. Becomes eligible for Medicare benefits.

#### **COVERAGE AND PREMIUM**

An eligible survivor may elect to continue coverage at any level of benefits currently offered to dependents of an active employee.

An eligible survivor is entitled to make payments for coverage or have payment made on the survivor's behalf at the same time and to the same entity that payment for coverage are made by the current employees of the plan; and

An eligible survivor will purchase the coverage at the same premium that the current employees/dependents of the plan are subject to.

#### **Special Enrollment**

If an Eligible Employee does not enroll for coverage for the Employee and/or the Employee's Eligible Dependents within thirty (30) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's special enrollment rules.

An Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

the Employee is eligible for coverage under the Plan but is not currently enrolled;

the Employee declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for not enrolling on the Employee's enrollment form; and

the alternative coverage has terminated, because either (i) it was COBRA continuation coverage that has been exhausted, or (ii) eligibility for the alternative coverage was lost (for reasons other than the individual's failure to pay premiums or for cause), (iii) termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility, (iv) employee or dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance, (v) or employer contributions toward the cost of the coverage terminated. In this case, the Employee must submit a completed enrollment form within 30 days after the date on which (1) COBRA continuation coverage was exhausted, or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in the Plan will be effective the first day of the first calendar month beginning after the date on which the Plan receives the completed enrollment form.

In addition, an Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

the Employee is eligible for coverage under the Plan but is not currently enrolled;

the Employee declined coverage under the Plan when it was offered previously; and

another individual (a spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form within 31 days of the marriage, birth, adoption or placement for adoption. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage; (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

In addition, an Eligible Employee may enroll for coverage for the Employee or an Eligible Dependent if either of the following conditions is met:

a Dependent child terminated coverage, was denied coverage, or was not eligible for coverage under the Plan, because, under the terms of the Plan, the availability of dependent coverage of children ended before the attainment of age 26 and the Dependent child is now eligible for coverage under the Plan effective as of January 1, 2011; or

an Employee or Dependent lost coverage or benefits under the Plan by reason of reaching a lifetime limit on the dollar value of all benefits for such individual, and such Employee or Dependent is now eligible for benefits not subject to a lifetime limit on the dollar value of all benefits under the Plan as of January 1, 2011.

If an Eligible Employee or Eligible Dependent satisfies either condition above, as applicable, the Eligible Employee or Eligible Dependent will be given an opportunity to enroll in the Plan that starts on the later of (1) the date the Eligible Employee or Eligible Dependent satisfies such condition or (2) the first day of the open enrollment period for the 2011 Plan Year and, in either case, continues for at least 30 days after such start date. This opportunity will be provided beginning not later than January 1, 2011, and coverage will be effective not later than January 1, 2011. Any Eligible Employee or Eligible Dependent enrolling in the Plan pursuant to this provision must be treated as if the Eligible Employee or Eligible Dependent were a special enrollee, as provided under HIPAA's portability provisions. Accordingly, the Eligible Employee or Eligible Dependent (and the Eligible Employee through whom the Eligible Dependent is eligible for coverage under the Plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage due to one of the conditions listed above. The Eligible Employee or Eligible Dependent also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to one of the conditions listed above.

## **Open Enrollment**

Eligible Employees may enroll for coverage during Open Enrollment Periods. Coverage for Eligible Employees enrolling during an Open Enrollment Period will become effective on January 1, unless the Employee has not satisfied the Waiting Period or has not yet begun work for the Employer, in which event coverage for the Employee and his Eligible Dependents will become effective on the day following completion of the Waiting Period or the day he actually begins work. "Open Enrollment Period" shall mean the month of December in each Plan Year.

**Transfer of Coverage**

If a husband and wife are both Employees and are covered as Employees under this Plan, and one of them terminates, the terminating spouse and any of his Eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an Employee or as a Dependent of the terminated Employee.

**Adjustments for Prior Coverage**

To the extent that coverages hereunder are a replacement of the prior plan offered by the Employer, any Deductibles satisfied, with respect to such Covered Persons under the prior coverage, will be deemed to be Deductibles satisfied under the Plan. Any continuous periods a Covered Person was covered under prior coverage(s) of the Employer will be deemed to be time covered under the Plan. Documentation of satisfied Deductibles is the responsibility of the Covered Person.

If, on the date the prior plan is replaced with this Plan, an Employee is Totally Disabled, coverage under this Plan will be provided to the Employee and his covered Dependents, upon payment of the required contributions, in accordance with the "Extension of Coverage During Absence from Work" provision of this Plan.

## TERMINATION OF COVERAGE

### **Employee Coverage Termination**

An Employee's coverage under this Plan shall terminate upon the earliest of the following:

- the date of termination of the Plan;
- the date of termination of participation in the Plan by the Employee;
- the day prior to the date of Employee's entry into the armed forces of any country;
- the date of expiration of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (the Employee shares in the cost);
- the date on which the covered Employee leaves or is dismissed from the employment of the Employer;
- the date the Employee ceases to be eligible for coverage under the Plan; and
- immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Notwithstanding the foregoing, coverage may only be retroactively terminated (1) if an Employee performs an act, practice or omission that constitutes fraud, (2) if an Employee makes an intentional misrepresentation of material fact, as determined by the Plan Administrator, or (3) as permitted under the Affordable Care Act and subsequent guidance issued thereunder. In addition, coverage may always be terminated retroactively for failure to pay contributions when due.

### **Dependent Coverage Termination**

A Dependent's coverage under this Plan shall terminate upon the earliest of the following:

- the date of termination of the Plan;
- the date coverage for Dependents terminates under the Plan;
- the date the Dependent becomes covered as an Employee under the Plan;
- the date of termination of the coverage of the Employee;
- the date the Covered Person no longer satisfies the Plan's definition of Dependent;
- the date of expiration of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (the Employee shares in the cost); or
- immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Notwithstanding the foregoing, coverage may only be retroactively terminated (1) if an Employee performs an act, practice or omission that constitutes fraud, (2) if an Employee makes an intentional misrepresentation of material fact, as determined by the Plan Administrator, or (3) as permitted under the Affordable Care Act and subsequent guidance issued thereunder. In addition, coverage may always be terminated retroactively for failure to pay contributions when due.

See "Extension of Coverage" and "Continuation of Coverage Option (COBRA)."

**Certificates of Coverage**

The Plan generally will automatically provide a Certificate of Coverage to any Employee or Dependent after the individual loses coverage under the Plan. In addition, a Certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

The Plan will make reasonable efforts to collect information applicable to any Dependents of the Employee and to include that information on the Certificate; however, the Plan will not issue an automatic Certificate for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

## **EXTENSION OF COVERAGE**

### **Extension of Coverage for Handicapped Dependent Children** (Available during the continuance of the Plan only)

If an already covered Dependent Child attains the age that would otherwise terminate his status as a Dependent, and:

if on the day immediately prior to the attainment of such age, the child was a covered Dependent under the Plan,

at the time of attainment of such age, the child is incapable of self-sustaining employment by reason of mental retardation, physical handicap, or disability that commenced prior to the attainment of such age, and

such child is primarily dependent upon the Employee for support and maintenance,

then such child's status as a Dependent shall not terminate solely by reason of his having attained the specified age, and he shall continue to be considered a covered Dependent under the Plan so long as he remains in such condition and otherwise conforms to the definition of a Dependent.

The Employee must submit to the Contract Administrator proof of the child's incapacity within 31 days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

### **Extension of Coverage During Absence From Work** (Available during the continuance of the Plan only)

If an Employee fails to continue in active employment due to Sickness, Injury, maternity leave, temporary layoff, entry into the armed forces, fraud, termination of Dependent coverage, when Dependent becomes an Employee, if participant no longer satisfies the definition of Dependent, or approved leave of absence, the Employee may be permitted to continue health care coverages for himself and his Dependents, though Employee could be required to pay the full cost of coverage during such absence. However, in no event can the extension under this provision be longer than 12 months.

Any such extended coverage offered by the Plan and elected by the Employee shall automatically and immediately cease on the earliest of the following dates:

the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this Plan;

the date of expiration of the period for which the last contribution was paid, if such contribution is required; or

the date and time of termination of this Plan.

This Plan is intended to conform with the applicable provisions of the Family Medical Leave Act of 1993.

### **Family and Medical Leave Act of 1993**

#### **A. Coverage**

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at

least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

## **B. Reasons for FMLA Leave**

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.
2. The placement of a son or daughter with you for adoption or foster care.
3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.
4. Because of a serious health condition that makes you unable to perform the functions of your position.
5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:
  - a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and
  - b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member's office, grade, rank, or rating.
6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

## **CONTINUATION OF COVERAGE OPTION (COBRA)**

This option does not apply to participants whose employers have fewer than 20 employees, in accordance with federal law.

In order to comply with COBRA, the Plan includes a continuation of coverage option that is available to certain Covered Persons whose health care coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law and its amendments, the law will prevail.

### **Definitions**

#### **Qualified Beneficiary**

Qualified Beneficiary is an Employee who was covered by the Plan on the day before the Qualifying Event or an Employee's Dependent who was covered by the Plan on the day before the Qualifying Event, or a child who is born to, or placed for adoption with, a covered Employee during continuation coverage.

#### **Qualifying Event**

Qualifying Event shall mean any one of the following that would result in the loss of coverage under the Plan: the death of the covered Employee, the termination of the covered Employee (other than by the Employee's gross misconduct), reduction in a covered Employee's hours of employment to an ineligible status, the divorce or legal separation of the covered Employee from the Employee's spouse, the Employee's coverage termination due to Medicare entitlement, or the cessation of covered Dependent child coverage by operation of a plan provision.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed 36 months (except for certain circumstances under COBRA's special bankruptcy rules for retirees and their Dependents).

### **Notification**

Employees must notify the employer or contract administrator within 60 days of a qualifying event in event of divorce, legal separation, or dependent child becoming ineligible. Qualified beneficiaries must notify the employer or contract administrator within 60 days of a qualifying event or secondary qualifying event in event of divorce, legal separation, or dependent child becoming ineligible.

The Plan Administrator must notify Qualified Beneficiaries of continuation of coverage rights in the event of the Employee's death, termination, reduction of hours, or entitlement to Medicare. Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to a spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made. Notification must be made to Qualified Beneficiaries within 44 days of the Plan Administrator's notice of the occurrence of a Qualifying Event.

### **Election and Election Period**

Continuation of coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

60 days after coverage ends due to a Qualifying Event; and

60 days after the Qualified Beneficiary receives notice of the continuation of coverage option rights.

If continued coverage is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries who would otherwise lose coverage. However, each individual who would otherwise lose coverage is entitled to make an individual election that would allow one to elect continued coverage even if others in the same family have declined, or, if optional benefits were available, an Eligible Employee and his Dependents could elect different coverage.

### **Effective Date of Coverage**

Continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and Qualified Beneficiary will be retroactively charged for coverage accordingly.

### **Level of Benefits**

Continuation coverage hereunder will be equivalent to coverage provided to a similarly situated Covered Person to whom a Qualifying Event has not occurred. If coverage of similarly situated Covered Persons is modified, the same modification shall apply to Qualified Beneficiaries.

### **Cost of Continuation of Coverage**

Except as provided below, the cost of coverage may be paid in monthly installments, and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of election of continuation of coverage hereunder. Thereafter, payments are due on the 1<sup>st</sup> day of each month to continue coverage for that month. If a payment is not made within 30 days of the due date, coverage will be cancelled and will not be reinstated. The American Recovery Reinvestment Act of 2009, (ARRA), temporarily provides federally subsidized COBRA premium assistance in the amount of 65%. This provision with regard to the ARRA only applies to those who were involuntary terminated, during the period beginning September 1, 2008 and ending December 31, 2009, unless otherwise extended by legislation.

### **Termination of Continuation of Coverage**

Coverage under this provision will terminate on the occurrence of the earlier of:

the end of 36 months, if the Qualifying Event is the death of the covered Employee, divorce or separation, Employee's entitlement to Medicare, or a Dependent child who no longer qualifies as a Dependent;

at the end of 18 months, if the Qualifying Event is termination of employment or reduction of hours to an ineligible status. However, in the case of a Qualified Beneficiary who is determined under the Social Security Act ("the Act") to have been totally disabled within 60 days of such Qualifying Event, the Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the continuation coverage) for a total of 29 months provided the Qualified Beneficiary notifies the Plan Administrator of the disability prior to the end of the 18 months of continuation coverage, and within 60 days of the determination of total disability under the Act. The cost for continuation coverage for months 19 through 29 will not exceed 150% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Further, if during continuation coverage months 19-29, the Qualified Beneficiary is finally determined under the Act not to be Totally Disabled, then the Qualified Beneficiary shall within 30 days notify the Plan Administrator, and continuation coverage shall terminate the last day of the month following 30 days after the date of the determination;

the termination of all group health plans provided by the Plan Sponsor;

the failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is more than 30 days delinquent in paying his premium);

the date the Qualified Beneficiary is covered under any other group health plan, as a result of employment, re-employment, or remarriage, that does not have a pre-existing condition that applies to the Qualifying Beneficiary; and

the date the Qualified Beneficiary becomes entitled to Medicare benefits.

### **Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, keep the employer or contract administrator informed of any changes in addresses of you or your family members.

### **Certificates of Coverage**

The Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan. Such certificates will be provided within the following time frames:

for an individual who is a Qualified Beneficiary entitled to elect continuation coverage, no later than when a notice is required to be provided for a Qualifying Event, as set forth above;

for an individual who is not a Qualified Beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and

for an individual who is a Qualified Beneficiary and who has elected continuation coverage, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under this provision.

## CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE

The procedures outlined below must be followed by Claimants to obtain payment of health benefits under this Plan.

### Health Claims

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

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

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

### Important Definitions

The following defined terms are used in this Claims Procedures section:

“Adverse Benefit Determination” means any of the following: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person’s eligibility to participate in the Plan; (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures; (3) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; or (4) a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

“Adverse Benefit Determination on Review” means the upholding or affirmation of an appealed Adverse Benefit Determination.

“Benefit Determination” means a determination by the Plan Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

“Benefit Determination on Review” means a determination by the Plan Administrator on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

“Claimant” means a Covered Person under the Plan, or his authorized representative or health care provider, who is designated by the Covered Person to act on his behalf.

“External Review” means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the Federal External Review process described in this Claims Procedures section.

“Final Internal Adverse Benefit Determination” means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules).

“Independent Review Organization” or “IRO” means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Under the Plan, there are three types of claims: Pre-service Non-urgent, Concurrent Care and Post-service.

### **Pre-Service Claims**

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

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

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

Further, since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no "Pre-service Urgent Care Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

### **Concurrent Claims**

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

It is important to remember that, in the event of an urgent care situation, the Covered Person need only notify CHR on the first business day after the additional stay begins. Since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

### **Post-service Claims**

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

### **When Health Claims Must Be Filed**

Health claims must be filed with the Contract Administrator within 12 months from the date on which Covered Expenses were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92:

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

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

### **Timing of Claim Decisions**

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the timeframes described under each type of claim listed below.

### **Pre-service Non-urgent Care Claims**

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

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

### **Concurrent Claims Plan Notice of Reduction or Termination.**

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

### **Request by Claimant Involving Non-urgent Care**

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

### **Post-service Claims**

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

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

### **Extensions – Pre-service Non-urgent Care Claims**

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

### **Extensions – Post-service Claims**

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

### **Calculating Time Periods**

The period of time within which a Benefit Determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

### **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically containing the following information:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. Reference to the specific Plan provisions upon which the determination is based;
3. A description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures and time limits applicable to such procedures, along with a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review;
5. If the Adverse Benefit Determination is based upon:
  - a. An internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
  - b. A medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
6. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
7. The reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
8. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and
9. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

## **Appeal of Adverse Benefit Determinations**

### **Full and Fair Review of All Claims**

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. A Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior Benefit Determination;
5. Each Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;
6. Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;
7. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
8. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Contract Administrator.

### **Requirements for Appeal**

The Claimant must file the appeal in writing within 180 days following receipt of the notice of an Adverse Benefit Determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows: Pre-service Non-urgent Claims –Prime Dx, P.O. Box 9201, Austin, Texas 78766, fax number 512-454-1624 or Post-service Claims – Boon-Chapman Benefit Administrators, Inc., Attention: Appeals, P.O. Box 9201, Austin, Texas 78766 Fax Number: 512-459-1552.

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

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

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

#### **Timing of Notification of Benefit Determination on Review**

The Plan Administrator shall notify the Claimant of the Plan's Benefit Determination on Review within the following timeframes:

#### **Pre-service Non-urgent Care Claims**

Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

#### **Concurrent Claims**

The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

#### **Post-service Claims**

Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

#### **Calculating Time Periods**

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

#### **Manner and Content of Notification of Adverse Benefit Determination on Review.**

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on Review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under section 502(a) of ERISA;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency";
8. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
9. The reason or reasons for the Final Internal Adverse Benefit Determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;
10. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and
11. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

## **External Review**

In accordance with the U.S. Department of Labor Technical Release 2010-01, the Plan will comply with the safe harbor for non-grandfathered self-funded group health plans not subject to a State External Review process, and therefore subject to the Federal External Review process, until superseded by future guidance. External Review will be available with respect to claims for medical benefits. However, a claim for dental benefits or a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet eligibility requirements under the Plan is not eligible for External Review.

1. Request for Standard External Review. A Claimant shall have four (4) months from the receipt of the notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination to submit a written request an External Review to the Plan Administrator.
2. Preliminary Determination. Within five (5) business days of receipt of a request for an External Review, the Plan Administrator shall complete a preliminary review of the request to determine whether:
  - a. The Claimant is or was covered by the Plan at the time the health care item or service in question was requested or provided, or that the health care item or service was covered under the Plan at the time the health care item or service was provided;
  - b. The Final Internal Adverse Benefit Determination does not relate to whether the Claimant satisfied the eligibility requirements of the Plan;
  - c. The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeal process under 29 C.F.R. § 2590.715-2719; and
  - d. The Claimant has provided all the information and forms required to process an External Review.
3. Preliminary Notice. If a request is not eligible for External Review, the Plan Administrator must issue a written notice to the Claimant within one (1) business day after the Plan Administrator completes the preliminary review, which must include the reasons the requested appeal is not eligible for External Review and contact information for the Employee Benefit Security Administration. If a request is not eligible for External Review because it is incomplete, the notice must include a description of the information necessary to complete the request and permit the Claimant to submit such information by the later of 48 hours after the Claimant receives the notice or by the end of the four (4) month period during which the External Review must be requested.
4. Standard External Review. If a claim is eligible for External Review, the Plan will assign the claim to an IRO that is one of at least three IROs retained by the Plan to conduct External Reviews and which is due to receive the claim on the Plan's rotational basis established to ensure independence. The external IRO will conduct a full review of the file, applicable Plan provisions and any material submitted as required by applicable guidance and in compliance with the IRO's contract with the Plan. The IRO will conduct this review on a de novo basis without deference to the Plan's decision.

Within five business (5) days after the Plan has assigned an IRO to review the claim, the Plan shall provide the documents and information considered by the Plan in making its Final Internal Adverse Benefit Determination. If the IRO receives any new evidence or information, it shall provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the Claimant and the IRO of its new decision within one (1) business day of making such decision. The IRO must then terminate its review.

The IRO shall provide the Claimant and the Plan with a written notice of its decision within 45 days of the date on which the IRO received the request for External Review. Such notice shall include all information required by applicable guidance.

Upon receipt of the IRO's final determination reversing the Plan's determination, the Plan shall immediately provide coverage or payment for the claim.

5. Expedited External Review. An expedited External Review shall be provided:
  - a. If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously

jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

- b. If the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged since receiving such emergency services.

Upon receipt of a request for an expedited External Review, the Plan shall determine if the request satisfies the requirements to be eligible for a standard External Review. The Plan must immediately send the Claimant a notice of such preliminary determination of eligibility.

If a claim is eligible for expedited External Review, the Plan shall assign the claim to an IRO. The IRO shall provide the Claimant and the Plan with a written notice of its decision as soon as possible, but in no event more than 72 hours after the IRO received the request for an expedited External Review. If the notice is not in writing, within 48 hours of the date the notice is provided, the IRO must provide a written confirmation of its decision to the Claimant and the Plan.

### **Exhaustion of Administrative Remedies**

No action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted. If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review under the Plan. The denial of the claim will become final and binding on all persons for all purposes.

If the Plan fails to strictly adhere to all the requirements of the Claims Procedures with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process. In such case, the Claimant may initiate an External Review and is also entitled to pursue any available remedies under Section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

### **Decision on Review to be Final**

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

### **Appointment of Authorized Representative**

A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

### **Unclaimed Benefits**

If, within twelve (12) months after any amount becomes payable hereunder to a Covered Person or Beneficiary, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

## DEFINITIONS

When used in this Plan Document, the following items shall have the meanings shown below. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

### **Accidental Bodily Injury**

Any accidental bodily Injury that occurs while an individual is covered under the Plan and that is caused by external forces under unexpected circumstances and that does not arise out of or in the course of the employment of the Covered Person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching are not considered Accidental Injuries.

### **Active Course of Orthodontic Treatment**

The period of time which begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

### **Affiliation Period**

A period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide coverage.

### **Ambulatory Surgical Center**

An institution or facility, either free standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a 24-hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

### **Birthing Center**

A special room in a Hospital that exists to provide delivery, prenatal, and postnatal care with a minimum of medical intervention, or a free-standing out-patient facility that:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

has organized facilities for birth services on its premises; and

provides birth services by Physicians, licensed registered graduate nurses (R.N.s), or midwife nurse practitioners when a patient is in the center.

### **Brand Name Drug**

A prescription drug which is or was at one time under patent protection.

### **Calendar Year**

The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:00 midnight on the next December 31. Each succeeding like period will be considered a new Calendar Year.

### **Calendar Year Maximum Benefit**

The most benefits the Plan will pay for Covered Expenses of a Covered Person Incurred during a Calendar Year.

### **Certificate of Coverage**

A written certification provided by any source that offers medical care coverage, including this Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

### **Claimant**

Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

**COBRA**

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Co-insurance**

See the Schedule of Benefits.

**Compound Drug**

A drug that contains at least one Legend Drug in therapeutic amount.

**Contract Administrator**

The company that provides claims adjudication and other ministerial services to the Plan in accordance with an administrative services agreement between the Contract Administrator and the Employer.

**Co-payment or Co-pay**

The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible or the Annual Out-of-Pocket Maximums.

**Covered Expense**

An expense incurred by a Covered Person that is payable by the Plan as Co-insurance or is payable by the Covered Person as a deductible, as Co-insurance, as a Co-payment, or because of a benefit.

**Covered Person**

A covered Employee, a covered Dependent, or a COBRA Qualified Beneficiary.

**Creditable Coverage**

Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

**Custodial Care**

The term "Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

**Deductible**

The term "Deductible" means the amount of covered expenses that must be incurred by a Covered Person before benefits will be paid by the Plan. No benefits will be paid for any charges applies toward the satisfaction of a deductible. See the Schedule of Benefits for more information.

**Dentist**

A person who is licensed to practice dentistry or Oral Surgery, practicing within the scope of his or her license, and not a member of your Immediate Family.

**Dependent**

See "Eligibility and Effective Dates."

**Durable Medical Equipment**

Durable Medical Equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

can withstand repeated use;

are primarily and customarily used to serve a medical purpose;

generally are not useful to a person in the absence of Sickness or Accidental Injury; and  
are appropriate for use in the home.

**Employee**

See "Eligibility and Effective Dates."

**Employer**

The entities listed in "Administrative Information" as participating employers.

**Generic Drug**

A generic substituted drug which costs less than the brand name drug prescribed, and is labeled under its chemical compound or generic name rather than under a trade or brand name, but is pharmaceutically and therapeutically equivalent to the brand name drug prescribed.

**Home Health Care Agency**

An agency or organization that:

is certified under Title 18 of the United States Social Security Act of 1965, as amended from time to time; or  
is certified to participate as a home health care agency in the area in which the services are rendered.

**Hospice Care Program**

An entity:

providing a coordinated set of services rendered at home, in an Outpatient setting, or in an institutional setting for Covered Persons suffering from a condition that has a terminal prognosis;  
that has an interdisciplinary group of personnel including at least one Physician and one licensed registered graduate nurse (R.N.);  
that maintains central clinical records on all patients; and  
meets the standards of the National Hospice Organization and applicable state licensing requirements.

**Hospital**

An institution that:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;  
is primarily engaged in providing medical treatment to sick and injured persons as registered bed-patients;  
has a staff of one or more licensed doctors of medicine or doctors of osteopathy available at all times;  
continuously provides a 24-hour-a-day nursing service by licensed registered graduate nurses (R.N.s);  
maintains facilities for diagnosis of Injury and disease;  
maintains permanent facilities for major surgical operations on its premises; and  
is not, other than incidentally, a place of rest, for Custodial Care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school, or a similar institution.

A Hospital will also include:

an institution that is legally constituted as a hospital and for which the laws of the state specify requirements other than those listed above and that is operated primarily for the care and treatment of sick and injured person as Inpatients;

an institution or facility that provides treatment for mental illness, provided that such institution or facility:

is licensed by the state licensing body or is approved by the state department responsible for such institutions or facilities; and

renders recognized treatment for the condition for which it is licensed or approved to operate; or

an alcohol dependency treatment center that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

affiliated with a Hospital under a contractual agreement with an established system for patient referral;

accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

### **Illness**

A bodily disorder, disease, physical Sickness, mental infirmity, Serious Mental Illness, functional nervous disorder or Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

### **Immediate Family**

You, your spouse, and the children, brothers, sisters, and parents of you and your spouse.

### **Incurred**

Expenses shall be deemed to be "Incurred" on the latest of the following dates:

the date a purchase is contracted;

the date delivery is made; or

the actual date a service is rendered.

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

### **Injury**

A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

### **Inpatient**

A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

### **Late Enrollee**

An individual who is allowed to enroll in the Plan, other than during the period of initial eligibility or during a special enrollment eligibility period.

### **Legend Drug**

Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription," and, shall include State Restricted Drugs (any non-federal Legend Drug which, according to state law, may not be dispensed without a prescription) and compounded prescriptions containing at least one Legend Drug as herein described in a therapeutic amount.

### **Maintenance Drug**

Any Legend Drug that is prescribed for the purpose of treating or preventing a chronic illness.

**Maximum Eligible Charge**

The Maximum Eligible Charge, as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

- The provider's normal charge for the same or a similar service or supply; or
- A selected percentile of Ingenix's MDR Payment System for non-facility services or supplies.

With regard to charges made by a provider of service participating in the Plan's PPO program, "Maximum Eligible Charge" shall mean the rates negotiated between the preferred provider organization and the participating providers.

**Medically Necessary or Medical Necessity**

When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

- be rendered in connection with an Injury or Illness;
- be consistent with the diagnosis and treatment of your condition; and
- be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate. Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
- it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;
- is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or
- is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

The sources of information to be relied upon are:

the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;

a Covered Person's medical records;

protocol pursuant to which the treatments is to be delivered; or

any regulations and publications set forth by any governmental agency.

**Medicare**

Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

**Mental and Nervous Care/Substance Abuse**

Such term includes treatment for mental and nervous disorders or conditions, as accepted by the general psychiatric community, including treatment for substance abuse.

**Nurse Anesthetist**

A Certified Registered Nurse Anesthetist (CRNA), who is a trained nurse who has specialized in anesthesia and possesses documented capability for giving anesthetics.

**Occupational Injury or Sickness**

Any Injury, Sickness or dental condition that the Covered Person has or had a right to compensation under any workers' compensation law, occupational disease law, or other law of similar purpose or that resulted from employment or occupation for compensation.

**Oral Surgery**

Medically Necessary procedures for Surgery in the oral cavity, including pre- and post-operative care.

**Outpatient**

Services rendered on other than an Inpatient basis.

**Physician**

A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

"Physician" also includes the following providers, but only when the provider is licensed to practice where the care is rendered and is rendering a service within the scope of that license:

Dentist (D.D.S. or D.M.D.);

Optometrist (O.D.);

Podiatrist or Chiropractist (D.P.M., D.S.P., or D.S.C.);

Psychologist (Ph.D.); and

Chiropractor (D.C.).

"Physician" will also include the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, and is rendering a service to an individual who was referred to him by an M.D. or D.O.:

Physical therapist (P.T. or R.P.T.);

Speech pathologist;

Audiologist;

Certified Registered Nurse Anesthetist (C.R.N.A.);  
Medical Social Worker (M.S.W.);  
Licensed Professional Counselor (L.P.C.);  
Physician's Assistant (P.A.);  
Certified Nurse Practitioner;  
Certified Midwife; and  
Occupational therapist (O.T.R.).

For purposes of certifying Total Disability, "Physician" will include only Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.).

**Plan**

The Harrison County Employee Benefit Plan

**Plan Administrator**

See "Administrative Information" Section.

**Plan Document**

This Plan Document and Summary Plan Description, which shall serve as both the Plan Document and the Summary Plan Description which is required by ERISA.

**Plan Sponsor**

See "Administrative Information" Section.

**Plan Year**

A period of time commencing at 12:01 a.m. on the effective date, or any anniversary of the effective date, of this Plan and continuing until the next succeeding anniversary.

**Pre-existing Condition**

See the Schedule of Benefits.

**Preferred Provider Organization (PPO)**

An organization that has contracted with the Plan Sponsor or the Contract Administrator to provide certain services to Covered Persons at specific rates. See the schedule of medical benefits for the special benefit level that applies to services obtained from contracted providers.

**Pregnancy**

Carrying a child, childbirth, miscarriage and complications arising there from.

**Prosthesis**

An artificial device to replace a missing part of the body or to aid the function of a bodily organ.

**Protected Health Information (PHI)**

Any information that identifies an individual, or reasonably could be used to identify an individual.

**Semi-private Room Charge**

The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or the lowest charge by the facility for single bed room and board accommodations if the facility does not provide any semi-private accommodations.

**Sickness**

Physician-diagnosed bodily illness or disease, or congenital abnormalities of a covered newborn child. Mental health conditions are not included.

**Significant Break in Coverage**

A period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include a Waiting Period or an Affiliation Period.

**Skilled Nursing Facility**

An institution that:

is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons and has facilities for the full-time care of at least five patients;

is under the full-time supervision of a Physician or a licensed registered graduate nurse (R.N.);

admits patients only upon the recommendation of a Physician;

maintains complete medical records;

has the services of a Physician available at all times; and

is not, other than incidentally, a nursing home, a hotel, a school, or a similar institution, a place of rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

**Spouse**

A person of the opposite sex who is a husband or wife.

**Surgery**

Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

**Temporomandibular Joint Dysfunction**

Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

**Total Disability or Totally Disabled**

With reference to an Employee, disability resulting solely from a Sickness or Accidental Injury that prevents the Employee from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training, or experience.

For a Dependent, disability that prevents the Dependent from engaging in substantially all the normal activities of a person in good health of like age and gender.

A Covered Person must also be under the care of a Physician (M.D. or D.O.) in order to be considered Totally Disabled for benefit purposes.

**Waiting Period**

The period that must pass before an Employee or Dependent can become effective under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment is not a Waiting Period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a Waiting Period.

## GENERAL PLAN INFORMATION

### Funding - Sources and Uses

#### Employee Obligations

The health care coverage afforded to an Employee by this Plan shall be at least partially funded by the Plan Sponsor. If an Employee elects to enroll Dependents under the Plan, the Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer shall deduct such costs on a regular basis from the Employee's wages or salary.

#### Plan Sponsor Obligations

The Plan Sponsor shall also make contributions to the Plan for health care coverage. These contributions and those paid by Employee, if any, shall be placed in a special account or accounts administered by the Contract Administrator.

#### Use of Contributions

The contributions will be applied to provide the benefits under the Plan. Contributions may be used to purchase insurance coverage to ensure that the Plan will meet its self-funded health care coverage obligations. The policy may be reviewed upon request submitted to the Contract Administrator. The Contract Administrator is also available to answer any questions about the coverages. The provisions of this Plan Document in no way modify those of any insurance policy. Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Employer and the Contract Administrator.

#### Amount of Contributions

The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Plan Sponsor and by Employees (if any).

#### Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan shall be paid by the Plan Sponsor.

### Administrative Provisions

#### Administration

The benefits of the Plan are administered by one or more Contract Administrators under the terms and conditions of administration agreements between the Employer and Contract Administrator.

#### Alternative Care

In addition to the benefits specified herein, the Plan Administrator has the discretion to provide benefits that would not otherwise be payable when and for so long as it determines that such benefits are less than the benefits the Plan would have to pay if it did not pay them.

If the Plan Administrator decides to pay such benefits in one instance, it shall not be obligated to provide the same or similar benefits in any other instance, nor shall such action be deemed to be a continuing waiver unless specifically stated therein.

#### Plan Administrator

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan

Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

#### **Duties of the Plan Administrator**

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

#### **Amending and Terminating the Plan**

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

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

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

#### **Annual Statements**

If required by law, the Plan Sponsor shall furnish to each Employee, within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

#### **Anticipation, Alienation, Sale, or Transfer**

No benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of or claims against any Covered Person, including claims of creditors, claims for alimony or support, or any like or unlike claims. The preceding shall not apply to a "qualified domestic relations order" defined in ERISA Section 206.

#### **Conformity With Applicable Laws**

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

**Entire Contract**

The Plan Document, any amendments, and the individual applications, if any, of Covered Persons shall constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any employee. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any employee or person any legal or equitable rights against the Plan Sponsor, the Plan Administrator, or their respective shareholders, directors or officers.

**Facility of Payment**

Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator determines that an Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan Administrator with an address at which he can be located for payment, the Plan Administrator may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee to the husband, wife, or relative by blood of the Employee or to any other person or institution determined by the Plan Administrator to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan Administrator may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brother, or sister, or to the Employee's estate, as the Plan Administrator in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator, or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

**Force Majeure**

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

**Fraud**

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which the Covered Person is a member:

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

**Free Choice of Physician**

Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

**Gender and Number**

Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

**Illegality of Particular Provision**

The illegality of any particular provision of this Plan Document shall not affect the other provisions, but this Plan Document shall be construed in all respects as if such invalid provision were omitted.

**Legal Actions**

Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to the Injury or Sickness are Incurred or are alleged to have been Incurred. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claim Procedures for Health Care Coverage."

**No Waiver or Estoppel**

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

**Physical Examination and Autopsy**

The Plan Administrator, at its own expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim and to make an autopsy in case of death, where it is not forbidden by law.

**Reimbursements**

Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor shall be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

**Right of Recovery**

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of this Plan Document, the Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Covered Person shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or his Dependents.

The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person or his parent or guardian shall execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its rights under this provision.

**Titles or Headings**

Titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of its provisions.

**Type of Plan**

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for Eligible Employees of the Employer, their Eligible Dependents, and Qualified Beneficiaries under COBRA.

**Workers' Compensation**

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.

## STATEMENT OF RIGHTS OF EMPLOYEES

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants are entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
3. 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.
4. 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 Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

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

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

**Assistance with Your Questions**

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

## HIPAA PRIVACY RULE AND SECURITY STANDARDS

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the “HIPAA Privacy Rule” and § 164.504(f) is referred to as “the “504” provisions”) which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

### **The Plan’s Designation of Person/Entity to Act on its Behalf**

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Velma McGlothin and/or Amy Holdeman to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (*e.g.*, entering into business associate contracts; accepting certification from the Plan sponsor).

### **The Plan’s disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor**

Except as provided below with respect to the Plan’s disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the “504” provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and
3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

### **Permitted disclosure of members’ Protected Health Information to the Plan sponsor**

The Plan (and any health insurance issuer or HMO servicing the Plan) will disclose members’ Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan’s members by a health insurance issuer or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this section and in the “504” provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members’ Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will not use or further disclose members’ Protected Health Information other than as described in the Plan Documents and permitted by the “504” provisions.

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members’ Protected Health Information received from the Plan (or from the Plan’s health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

The Plan sponsor will not use or disclose members’ Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the “504” provisions, of which the Plan sponsor becomes aware.

### **Disclosure of members’ Protected Health Information – Disclosure by the Plan sponsor**

The Plan sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. § 164.524.

The Plan sponsor will make members’ Protected Health Information available for amendment and incorporate any amendments to members’ Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of members' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described below, is established and maintained.

**Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor**

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

**Required separation between the Plan and the Plan sponsor**

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to members' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Velma McGlothlin, Human Resources
2. Jana Smallwood, Accounting
3. Judge Hugh Taylor
4. Dawn Jones, Auditor
5. Amy Holdeman, Purchasing Agent

This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive members' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

## **Security Standards**

### **Plan Sponsor Obligations**

Where Electronic Protected health Information will be created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates received, maintains, or transmits on behalf of the Plan;
- B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
  - 1. Plan sponsor shall report to the plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
  - 2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.