GROUP BENEFITS PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

CITY OF MURRAY
EMPLOYEE BENEFIT PLAN

BUY-UP PLAN

EFFECTIVE 1/01/2014

Dear Plan Participant:

This Plan includes health coverage (which includes prescription drug card benefits), vision, and dental benefits. If you elect family coverage, your dependents will receive the same type of coverage as you.

This booklet has been prepared to explain the health care coverage available to you through the City of Murray Employee Benefit Plan. We recommend that you read the booklet and become familiar with the various types of coverages and benefits to which you (and if family coverage is elected, your dependents) may be entitled should the need arise. This document serves as both the official Plan Document and Summary Plan Description.

The day-to-day management of the Plan has been delegated to a professional Third Party Administrator, North America Administrators, L.P. Should you have any questions regarding the Plan, its operation and benefits, as well as any claim decisions or payments, please do not hesitate to contact North America Administrators, L.P. either by mail at:

City of Murray Health Care Plan
P.O. Box 1984
Nashville, TN 37202

or by telephone at: (615) 256-3561 or (800) 411-3650.

The administrative staff will be available during normal working hours to assist you.

This booklet contains a summary in English of your plan rights and benefits under this plan. If you have difficulty understanding any part of this booklet, contact City of Murray (the plan administrator) at 608 Main Street, Suite A, Murray, KY 42071. You may also call the plan administrator's office at 270-753-7278 for assistance.

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I. SCHEDULE OF BENEFITS

A. COMPREHENSIVE MEDICAL BENEFITS

ANNUAL MAXIMUM BENEFITS:

All Conditions - Other internal limits may apply.....unlimited
Accidental Dental (surgery and anesthesia).....$3,000.00*
Home Health Care.....100 visits
Skilled Nursing..... 100 days
*This limit will not apply to outpatient facility charges, anesthesia billed by a Provider other than the Physician performing the service, or to services that the Plan is required by law to cover.

OTHER MAXIMUM BENEFITS:

Hearing Aids for children under age 18.....$1,400.00 per ear, every 3 years
Transplant travel and lodging (In Network only).....$10,000.00
Transplant unrelated donor searches for bone marrow/stem cell.....$30,000.00

	PPO PROVIDERS	NON-PPO PROVIDERS
Calendar Year Deductible Amount:		
Per Individual	$1,500.00	$3,000.00
Per Family	$3,000.00	$9,000.00

The Deductible amount is embedded. The PPO and NON-PPO Calendar Year Deductible Amount do not share (do not accumulate towards each other).

Out-of-Pocket Maximum Including Deductible:		
Per Individual	$3,000.00	$6,000.00
Per Family	$6,000.00	$12,000.00

The Out-of-Pocket Maximum is separate. The PPO and NON-PPO Out-of-Pocket Maximum do not share (do not accumulate towards each other). Once the Out-of-Pocket Maximum has been reached for the calendar year coinsurance will be required for the remainder of the calendar year.

After the Individual (or Family) Out-of-Pocket Maximum has been reached for the calendar year, the Plan will pay 100% of subsequent covered expenses incurred by the individual (or family) during the remainder of that calendar year. However, when there is other secondary coverage for the same Illness or injury for which benefits are payable, the Plan will continue to pay at the applicable co-insurance percentage.

The following expenses will not be applied toward the satisfaction of the Out-of-Pocket Maximum nor will benefits ever be payable at 100%: Any Penalties; Prescription benefits, Out of Network Transplant services; Non-covered services; Any covered expense for which benefits were initially paid at 100%.

Benefits % Payable by the Plan:	80%	60%

- subject to Deductible
- all Covered Expenses except as otherwise stated
- payment based on setting where covered services are received

Covered expenses for emergency room Physicians, anesthesiology, pathology or radiology will be paid at the PPO Benefits % Payable, even if the provider is not a member of the PPO Network, provided such services are rendered in a PPO facility. In addition, covered expenses in connection with any services rendered by a PPO Provider

will be paid at the PPO Benefits % Payable. Please note: These charges will be subject to the usual and customary charge limits and the Employee may be responsible for any balance charged by the Physician.

	PPO PROVIDERS	NON-PPO PROVIDERS
Advanced Imaging - includes MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies and non-maternity related ultrasounds. - regardless of setting where services were received.	80% after Deductible	60% after Deductible
Ambulance	80% after Deductible	80% after Deductible
Chiropractic Care	80% after Deductible	60% after Deductible
Emergency Room - includes all charges related to emergency room visit	80% after Deductible	80% after Deductible
Hospice	100% no Deductible	60% after Deductible
Mammogram (diagnostic)	100% no Deductible	60% after Deductible
Physician Office Visit		
Primary Care Physician - includes all services performed in Physician's office, except advanced imaging. - includes associated radiology and pathology charges for the services performed in Physician's office	80% after Deductible	60% after Deductible
Specialist - includes all services performed in Physician's office, except advanced imaging. - includes associated radiology and pathology charges for the services performed in Physician's office - includes psychotherapy	80% after Deductible	60% after Deductible
Preventive Care	100% no Deductible	60% after Deductible

The preventive care benefit includes the following:

1. Services with an A or B rating recommended by the United States Preventive Services Task Force (USPSTF).
2. Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the

Health Resources and Services Administration (HRSA).
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of USPSTF).
5. All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.
6. Routine physical exam and associated diagnostic tests as listed above.
7. Prostate Specific Antigen tests.

	PPO PROVIDERS	NON-PPO PROVIDERS
Transplant	100% no Deductible	50% after Deductible

Your PPO is Cigna. To find a provider or facility near you, please contact Cigna at www.myCIGNA.com.

Cigna will expand its relationship with chiropractic network American Specialty Health Networks, Inc. (ASHN) to all PPO membership in the following states: AZ, CA, CT, DE, DC, GA, KS, LA, MA, MD, MO, NJ, NY, OH, PA, RI, TN, TX and Northern VA. Claims will go the GWH-Cigna address found on the participant's ID card

MedSolutions, Inc. (MSI) is the Cigna vendor that provides utilization management for the National Radiology Network. Utilization management services are provided on a national basis for all outpatient elective non-emergent (e.g., rendered in any setting other than an ER or IP hospital) MRIs, MRAs, CT, and PET imaging services. Their phone number is 1-888-693-3295. The billing address is:

MedSolutions, INc.
P O Box 282488
Nashville TN 37228

CareCentrix is a national health care provider of traditional home healthcare, home infusion therapy, and medical and respiratory equipment (DME) services. Home healthcare is coordinated through the CareCentrix credentialed health care professional network, or any other Cigna provider. Their phone number is 1-888-999-2422. The billing address is:

CareCentrix
P O box 538059
Atlanta, GA 30353

B. PRESCRIPTION DRUG CARD BENEFIT

Pharmacy Co-pay (30 day supply maximum)
- Generic .....10% (minimum $5)
- Brand .....30% (minimum $10)
- Medications recommended by the HRSA and USPSTF $0.00

Pharmacy Co-pay (60 day supply maximum)
- Generic .....10% (minimum $10)
- Brand .....30% (minimum $20)
- Medications recommended by the HRSA and USPSTF $0.00

Mail Order Co-Pay (90 day supply maximum)

Generic .....10% (minimum $15)
Brand .....30% (minimum $30)
Medications recommended by the HRSA and USPSTF $0.00

Specialty Drugs Pharmacy or Mail Order Co-pay (30 day supply maximum)

Generic .....10% (minimum $5)
Brand .....30% (minimum $10)

Specialty Drugs Pharmacy or Mail Order Co-pay (60 day supply maximum)

Generic .....10% (minimum $10)
Brand .....30% (minimum $20)

Out of Network Specialty Drugs Pharmacy or Pharmacy Co-pay (30 day supply maximum).....50% (minimum $30)

Note: Co-payments do not apply to Medical Deductibles or Out-of-Pocket Maximums. Certain specialty drugs (including but not limited to oral HIV drugs and Immunosuppressants drugs) may be dispensed in up to a 90 day supply, subject to the Mail Order co-payments listed above. The Participant must purchase Generic drugs when available. If the Participant chooses to purchase the brand name drug when a Generic drug is available, the Participant will be responsible for the brand name drug co-payment as well as the difference in cost between the brand drug and the Generic prescription unless "DAW or "Dispense as Written" is ordered by the prescribing Physician. No prescription drug coverage is provided for any dependent who has primary drug coverage under another Employer sponsored group health plan.

C. DENTAL BENEFITS - OPTIONAL

Calendar Year Deductible*

Per individual.....$25.00
Employee + 1 .....$50.00
Per family $75.00

*Deductible applies to Class B & C Services

Calendar Year Maximum:

Class A, B, and C combined $1,500.00
Class D.....$500.00

% Payable

Class A – Preventive.....100%
Class B – Basic 80%
Class C – Major.....50%
Class D – Orthodontia.....50%

D. VISION CARE BENEFITS - OPTIONAL

Calendar Year Deductible ..... None
Percent Payable 100%

Covered Vision Care Expenses

Vision Exam.....$10 co-pay

Prescription lenses (including factory scratch coating polycarbonate lenses for children under 19 years old and photochromic lenses for children under 19 years old):

Single vision, bifocal, and trifocal (pair). ..... $20 co-pay

Frames..... $0 co-pay up to $130.00

Contact Lenses:
Non-Elective ..... $0 co-pay
Elective ..... $0 co-pay up to $130.00

NOTE: If contact lenses are chosen, no benefits will be available for eyeglass lenses and frames in that period. Contacts are available in lieu of glasses.

Frequency Limitation

Vision Exam..... Once every 12 months

Prescription lenses or contact lenses, or
12 months supply of disposable contact lenses. ..... Once every 12 months

Frames..... Once every 24 months

II. UTILIZATION REVIEW

A. IMPORTANT NOTICE - PENALTY

Utilization review is a program which reviews the setting, necessity and quality of health care. We will furnish each individual with utilization review through North America Administrators, L.P. **NORTH AMERICA ADMINISTRATORS, L.P.'S PHONE NUMBER IS 1-800-411-3650 extension 280.**

THE INDIVIDUAL IS RESPONSIBLE FOR CONTACTING NORTH AMERICA ADMINISTRATORS, L.P. TO OBTAIN THE REQUIRED PRE-AUTHORIZATION FOR:

- Inpatient Hospital Stays;
- Continuing Hospital Stays over 48 hours following vaginal delivery;
- Continuing Hospital Stays over 96 hours following a cesarean section;
- Outpatient Stays Over 48 Hours;
- Outpatient Surgeries (as required by utilization review carrier);
- Mental Health/Chemical Dependency Partial Hospitalization
- Home Health Care and Skilled Nursing Care;
- Speech Therapy
- Diagnostic Services: MRI, MRA, PET, and CAT Scan.

THE INDIVIDUAL IS RESPONSIBLE FOR CONTACTING MED-CERT AT 1-866-633-2378 Option 4 FOR:

- Outpatient Chemotherapy and Radiation Therapy
- Pain Management

Utilization review is performed only for the purpose of reviewing the medical necessity of the above services for the care and treatment of an Illness. **Authorization by North America Administrators, L.P. does not guarantee that all charges are covered under the Plan.** Charges submitted for payment are subject to all terms and conditions of the Plan.

As part of the utilization review process, North America Administrators, L.P. will also review for alternate methods of medical care or treatment.

It is the Employee or Covered Person's responsibility to make certain that the compliance procedures of this program are complete. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

FAILURE TO CALL PENALTY: If the individual fails to call for authorization for inpatient hospital **a penalty of $300.00 will apply. This penalty is in addition to any other Deductible or co-pay under this Plan.**

B. CERTIFICATION/PRE-CERTIFICATION

1. **Hospital Admissions:** The individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified of Hospital stays **before** admission to a Hospital as a bed patient. NORTH AMERICA ADMINISTRATORS, L.P. will review the Physician's recommendation to determine whether a Hospital stay is necessary or if the procedure can be safely performed on an outpatient basis. Hospital admission will include outpatient confinements which exceed 48 hours in length. **If authorization for Hospital admission is denied, no benefits will be paid for Hospital charges.**

2. **Outpatient Stays Over 48 Hours:** For any outpatient stay that extends beyond forty-eight (48) hours, the individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified within 48 hours. For outpatient confinement on a holiday, or after 5:00 p.m. on a Friday, or during a weekend, NORTH AMERICA ADMINISTRATORS, L.P. must be informed of the stay by the second business day. Benefits will be paid only for authorized stays. **If authorization is denied, no benefits will be paid.**

3. **Outpatient Surgery:** The individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified **before** outpatient surgery is performed in other than a Physician's office. NORTH AMERICA ADMINISTRATORS, L.P. will review the Physician's recommended course of treatment. **If authorization is denied, no benefits will be paid.**

4. **Emergency/Urgent/Hospital Admission:** For an emergency or urgent Hospital admission, the individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified within 48 hours after admission. For admission on a holiday, or after 5:00 p.m. on a Friday, or during a weekend, NORTH AMERICA ADMINISTRATORS, L.P. must be informed of the admission by the second business day. **Benefits will only be paid for authorized days.**
   - "Emergency Hospital admission" means an admission for Hospital confinement, which, if delayed, would result in a disability or death.
   - "Urgent Hospital admission" means admission for a medical condition resulting from injury or Illness which is less severe than an emergency admission but requires care within a reasonably short time. This includes pregnancy related conditions other than childbirth.

5. **Childbirth Related Admission:** Group health Plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).
   - Continuing Hospital stays **over 48 hours** following vaginal delivery. When a Hospital confinement extends beyond forty-eight (48) hours following normal vaginal delivery, the individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified within 24 hours of the need for continued confinement.
   - Continuing Hospital stays **over 96 hours** following a cesarean section. When a Hospital confinement extends beyond ninety-six (96) hours following a cesarean section, the individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified within 24 hours of the need for continued confinement.
   - Benefits for Hospital confinements which exceed 48 hours following a vaginal delivery or which exceed 96 hours following a cesarean section will be paid only for authorized extended stays.

6. **Second Opinion -** A "second opinion" may be required for inpatient admissions or outpatient services. NORTH AMERICA ADMINISTRATORS, L.P. will inform the Physician if a second opinion is necessary. NORTH AMERICA ADMINISTRATORS, L.P. will explain to the individual requiring a second opinion which Physician's opinion will be acceptable.
   - A second opinion means an evaluation of the need for inpatient admission for

outpatient treatment by a second Physician (or third Physician if the opinion of the Physicians conflict) including the Physicians exam of the patient and diagnostic testing.

- A second opinion required by NORTH AMERICA ADMINISTRATORS, L.P. will be paid at 100% with no Deductible.
- If a second opinion was not approved by NORTH AMERICA ADMINISTRATORS, L.P., benefits will be subject to the normal Plan Deductible and co-insurance factors.

7. **Healthcare Services and Supplies Review:** The individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified to obtain a Plan of care approval for the following healthcare services and supplies: Home Health Care; Skilled Nursing Care; Speech Therapy. **If authorization is denied, no benefits will be paid.**

8. **Diagnostic Services:** The individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified **before** services are performed for the following non-emergency diagnostic tests: MRI, MRA, PET, and CAT Scan. NORTH AMERICA ADMINISTRATORS, L.P. will review the Physician's recommended course of treatment. **If authorization is denied, no benefits will be paid.**

9. **Mental Health/Chemical Dependency Partial Hospitalization.** The individual is responsible for making sure NORTH AMERICA ADMINISTRATORS, L.P. is notified of Hospital stays **before** mental health/chemical dependency partial hospitalization. Partial hospitalization is an inpatient level of care but is defined as partial stays anywhere from 5-7 days a week and are usually 8 hours a day - with customers not in programming in the evenings and weekends (if applicable). **If authorization is denied, no benefits will be paid.**

C. CONCURRENT REVIEW

After admission to the Hospital, NORTH AMERICA ADMINISTRATORS, L.P. will continue to evaluate the patient's progress. If, after consulting with the Physician, NORTH AMERICA ADMINISTRATORS, L.P. determines that continued confinement is no longer Medically Necessary, the individual and the Physician will be advised. **No benefits will be paid for Hospital days not authorized.** Please refer to claims review and appeal procedures section.

D. RETROSPECTIVE REVIEW

NORTH AMERICA ADMINISTRATORS, L.P. will evaluate the medical records of those individuals whose medical treatment or Hospital stay was not reviewed under Certification/Pre-Certification or Concurrent Review as described above.

If NORTH AMERICA ADMINISTRATORS, L.P. is unable to authorize any portion of the stay or treatment, the Physician will be contacted to provide additional information.

Benefits will be paid only for those days or treatment which would have been authorized, subject to the terms of the Plan. No benefits will be paid for any days or treatment not Medically Necessary.

E. CASE MANAGEMENT

Case Management is a program designed to assist the patient, their family and the attending Physician in the development and coordination of an appropriate Plan of care in

the event of a catastrophic condition which requires specialized and/or long-term care.

Upon consultation with and approval by the patient and attending Physician, the services of a case manager may include: Identification of alternative care options, monitoring of healthcare, assistance in obtaining needed healthcare equipment and services, and personal support to the patient and the family.

This is a voluntary program and there are no reductions of benefits or penalties if the patient and family choose not to participate. However, subject to the Plan Administrator's approval, benefits may be payable for expenses authorized under a case management program which are not otherwise expressly covered under the Plan. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

III. SUMMARY OF BENEFITS

A. COMPREHENSIVE MEDICAL BENEFITS

1. COVERED EXPENSES

a. Medical expense coverage for eligible Participants

Covered Expenses are charges for the following services and supplies, which are certified by the attending Physician, or other appropriate covered Provider, to be Medically Necessary for treatment, to the extent that the charges do not exceed the Reasonable and Customary or the allowable PPO Amount:

1. **Allergy Services.** Medical care for allergy testing and allergen immunotherapy, including the provision and injection of allergenic extracts.

2. **Ambulance.** Local ground and air ambulance service from home, scene of accident or medical emergency to, from, and between the nearest Hospital and/or Skilled Nursing Facility where care and treatment of the Injury or Illness can be given.

3. **Ambulatory Surgery Center/Birthing Center/Urgent Care Center.** Medically Necessary charges incurred in an ambulatory surgery center, lawfully operating birthing center, or urgent care center.

4. **Anesthesia.** Anesthetics and their administration, including the services of a Certified Registered Nurse Anesthetist (C.R.N.A.).

5. **Chiropractic Care.** Modalities (hot, cold therapy, etc.), manipulation, x-rays, and adjunctive therapy by a covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

6. **Clinical Trial.** Routine patient costs incurred as a result of participating in an approved phase I, II, III, or IV clinical trial. A phase I, II, III, or IV trial is an approved clinical trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted, and:
   a) is federally funded, or
   b) is either:
      i) conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration, or
      ii) is a drug trial that is exempt from the IND application requirements.

   A clinical trial is federally funded if it is approved and funded by one or more of the following agencies or entities:
   a) National Institutes of Health (NIH)
   b) Centers for Disease Control and Prevention (CDC)
   c) Agency for Health Care Research and Quality (AHRQ),
   d) Centers for Medicare and Medicaid Services (CMS),
   e) A non-governmental research entity identified in the NIH guidelines for center support grants,
   f) Department of Defense, Department of Veterans' Affairs or Department of Energy (if the trial has undergone an unbiased, scientific peer review by experts without a conflict and the Department of Health and Human Services Secretary deems the review to be comparable to the NIH peer review system), or
   g) Cooperative group or center of any of the above agencies, other than

Department of Energy.

Benefits do not include the following:

a) A health care service, item, or drug that is the subject of the clinical trial or is provided solely to satisfy data collection and analysis needs for the clinical trial that is not used in the direct clinical management of the patient;
b) Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial;
c) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
d) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
e) Out of Network benefits except if the approved clinical trial is only offered outside the patient's state of residence.

7. **Cochlear Implant.** Benefits are provided for services and supplies for a cochlear implant.

8. **Contraceptives.** Medications, injections, implants, or other contraceptive methods (including the fitting, insertion, and removal of contraceptives) which are recommended by the HRSA and USPSTF.

   Note: Contraceptives which can be obtained through the pharmacy are covered under the Plan's prescription drug program.

9. **Cosmetic Services.** Cosmetic Services are covered only when Medically Necessary for the following:
   a) Correction of a congenital birth defect for a Covered Person.
   b) Correction of conditions resulting from the prompt repair of a traumatic injury which is treated within 36 months of the injury and treatment is performed while the patient is covered under the Plan; or
   c) Reconstruction of breasts as part of a continuous treatment Plan after a Medically Necessary mastectomy, including prostheses and physical complications of all stages of mastectomy, including lymphedemas, and surgery and reconstruction of the other breast to produce a symmetrical appearance.
   d) A breast reduction procedure, which is not subsequent to a mastectomy, will be covered when Medically Necessary to treat another medical condition(s) resultant from excessive breast size. Prior approval by the Plan is required. The Participant must submit a request in writing to the Plan and must provide any medical records or other documentation as requested.

10. **Diabetes.** Diabetes outpatient self-management training and education services, including medical nutrition counseling, when prescribed by a Physician as Medically Necessary for the treatment of diabetes. Diabetic supplies will be eligible for medical benefits only if the expense is not covered under the Prescription Drug Card benefit.

11. **Diagnostic x-ray and laboratory services.** Charges for diagnostic laboratory, imaging, and diagnostic x-rays, including electrocardiograms, basal metabolism tests, and similar diagnostic tests commonly accepted by Physicians throughout the United States.

12. **Dialysis Services and Supplies**. Dialysis services, including equipment rental, supplies, upkeep and training for you or your dependents to use this equipment.

13. **Durable Medical Equipment.** Charges for the rental, but not to exceed the purchase

price, of Durable Medical Equipment (DME). At the Plan's option, authorization may be made for the purchase of such DME in lieu of its rental. Approval for purchase must be obtained in advance. Coverage is also provided for necessary repairs to keep such purchased equipment serviceable. No coverage is provided for duplicate DME rentals or purchases (this does not include replacement if the equipment is beyond repair).
Durable Medical Equipment includes such items as an apnea monitor, cervical collar, crutches, dialysis equipment, Hospital bed, non-motorized wheelchair, oxygen equipment, ventilator, Continuous Passive Motion (CPM) devices, Transelectrical Nerve Stimulation (TENS) devices, Augmentive communication devices, or other items which meet the requirements indicated. However, only items which meet all of the requirements below will be covered under the Plan.

Equipment which:

a) Can stand repeated use; and,
b) Can only be used to serve the medical purpose for which it is prescribed; and,
c) Generally, is not useful to a person in the absence of an Illness or an injury; and,
d) Is appropriate for use in the home; and,
e) Is basic, non-luxury, equipment; if the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat the condition, reimbursement will be based on the Reasonable and Customary Amount for a standard item that is a covered service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Reasonable and Customary Amount for the standard item is the participant's responsibility; and,
f) Is prescribed by a legally qualified Physician.

14. **Electrical Bone Growth.** Any charges related to electrical bone growth stimulation.

15. **Hearing Aid.** The Plan shall provide coverage of up to $1,400.00 per individual hearing aid per ear, every 3 years for covered dependent children under age 18. If a licensed audiologist or physician certifies that the child's hearing loss has become significantly worse during the 3 year period since the child received a hearing aid, coverage shall be provided for a new hearing aid suitable to the child's hearing needs before the end of the 3 year period.

16. **Home Health Care Expenses.** Benefits are provided for eligible charges for care furnished by a home health care agency up to the limits as stated in the schedule of benefits. The benefits are subject to the following conditions:
    a) The patient is under the care of a Physician who submits a "home health care Plan" (a written program for care and treatment in the patient's home)
    b) The Physician must certify that inpatient confinement in a Hospital, convalescent nursing home or Skilled Nursing Facility would be required if the home care weren't provided.
    c) The care is pre-certified and approved as specified in the Utilization Review Section.

    The eligible expenses are the charges for the following services and supplies ordered by the Physician under the home health care plan and furnished in the patient's home.
    a) Part-time or intermittent nursing care provided or supervised by an R.N.
    b) Part-time or intermittent home health aide services, primarily for the patient's care.
    c) Physical, occupational, speech or respiratory therapy by a qualified therapist.
    d) Nutrition counseling provided by or under the supervision of a registered dietician.
    e) Medical supplies, laboratory services, drugs and medications prescribed by a

Physician.

17. **Hospice Care.** Benefits are available under this provision when your Physician recommends in writing a hospice care Plan on or before such hospice care is started, provided:
    a) The hospice care is for palliative care of a terminal Illness (where life expectancy is less than 6 months); and
    b) You or your covered dependent elect (in writing) to follow the Physician's proposed treatment Plan;

    Covered services are:
    a) Room and board including daily services and supplies while inpatient in a Hospice;
    b) Services and supplies furnished by a Hospice team member on an outpatient basis;
    c) Part-time, intermittent or round-the-clock nursing by a Registered Nurse or a Licensed Practical Nurse;
    d) Medical social services under the direction of a Physician;
    e) Part-time (not more than 8 hours in one day) or intermittent care by a home health care aide;
    f) Medical supplies and prescription drugs; and
    g) Bereavement services.

    Benefits which are paid under this provision for any Covered Expense will not be duplicated under any other Plan provision. These benefits are in lieu of any other Plan coverage for treatment related to the terminal Illness. Coverage under this provision ends if you elect (in writing) to discontinue hospice care.

    Exceptions - Hospice care benefits are not payable for: services provided by persons who do not regularly charge for their services; counseling which is not provided as part of the hospice care plan; services provided by homemakers, caretakers and the like; funeral expense; or treatment intended to cure the terminal Illness.

18. **Hospital Care.**
    a) Hospital room, board and general nursing care not to exceed the Hospital's most common semi-private room rate (or the rate for ICU, CCU, or other special care units).
    b) Charges for other inpatient or outpatient Hospital services and supplies necessary for treatment of Injury or Illness. Services furnished by outside agencies and supplies not used while confined in the Hospital or as an outpatient are not covered.

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

20. **Medical Supplies.** Benefits are payable for the following disposable or non-durable medical supplies:

a) Blood and blood plasma, if not replaced
b) Casts, splints, trusses or braces.
c) Glucometers, dextrometers, destrostix, and infusion pumps (except as covered under the Prescription Drug Benefit)
d) Initial post-mastectomy prosthesis and mastectomy bra (limited to four per year)
e) Lenses (contact or glasses) when immediately following and which are Medically Necessary due to any eye surgery which is otherwise covered under this Plan.
f) Ostomy/colostomy supplies and catheters
g) Oxygen
h) Surgical dressings and supplies, surgical hosiery, compression hosiery and pressure garment, and stump socks
i) Total enteral or parenteral nutrition
j) Injections administered by a Physician that are not otherwise excluded by the Plan

21. **Mental and Emotional Conditions/Chemical Dependency.** Services and supplies related to a diagnosed Mental and Emotional Condition, or Chemical Dependency, including services provided by a licensed Physician, psychologist, psychiatrist, licensed clinical social worker, family therapist, or other mental health providers who are certified and licensed by the state in which he or she practices are covered if the following is met:
    a) The diagnosis must be specifically classified by reference to the most current version of the International Classification of Diseases published by the U.S. Department of Health and Human Services.
    b) If the condition is not considered subject to improvement by generally accepted standards, charges for subsequent evaluation and diagnosis of that condition are not covered.
    c) The care must fall into one of the following categories:
        i) Individual psychotherapy
        ii) Family counseling for members of the Participant's family
        iii) Group therapy
        iv) Psychological testing by a Psychologist
        v) Electroshock therapy
    d) Charges for services or supplies provided by or at a residential care facility or halfway house are not covered.

22. **Oral Surgery.** Charges will be covered for the following services:
    a) excision of tumors or cysts or incision or drainage of an abscess or cyst;
    b) treatment of accidental injury to Sound Natural Teeth (including their replacement), provided treatment is completed within 12 months of the injury (breaking or chipping of a tooth while eating is not considered an accident);
    c) Hospital services may be covered provided such services are Medically Necessary to safeguard the health of the Covered Person from the effects of a dental procedure due to a specific non-dental organic impairment.

23. **Orthotics and Prosthetics**. Orthotic devices such as braces, built-up shoe, shoe inserts, splints or other appliances which are custom designed and prescribed by a Physician for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness. Orthotic devices may include devices which are prefabricated, including but not limited to a walking boot or elbow brace, provided they are prescribed by a Physician and obtained from the Physician or a Durable Medical Equipment supplier. Over the counter orthotic devices or devices which can be obtained without a prescription are not covered. Orthotic appliances may be replaced once per year when Medically Necessary. However, additional replacements will be allowed for Participants under age 18 due to rapid growth, or for any Participant when an appliance is damaged and cannot be repaired. Orthopedic shoes (except therapeutic shoes for diabetics), arch supports and

corrective shoes (unless they are an integral part of a leg brace) are not covered. Prosthetic appliances, which replace all or part of an absent body part, or which replace all or part of the function of a permanently inoperative or malfunctioning body part are covered. The initial charge for any such appliance or device and any fitting, repair, or replacement due to pathological changes and normal growth shall be considered a covered expense. Applicable taxes, shipping and handling are also covered.

24. **Physician's Fees**. Physician's fees for medical care and surgical operations which do not exceed the Reasonable & Customary Amount. When available in your area, coverage will include online visit services. Covered services include a medical consultation using the internet via webcam, chat or voice. Online communication is not covered for billing, insurance coverage or payment questions, request for referrals, and Physician to Physician consultations. No payment will be made for Physician visits on or after the day a surgical operation is performed if these visits are made by the Physician who performed or assisted in the surgery, or for more than one inpatient visit per day by the Physician who performed or assisted in the surgery, or by more than one attending Physician unless you are being treated for more than one diagnosis while in Hospital. Consultations will be allowed limited to one consultant per specialty during a hospital confinement.
    - **Assistant Surgeon** - Charges for Medically Necessary services of an Assistant Surgeon (a Physician who actively assists the Surgeon in the performance of a covered surgical procedure), will be covered up to the PPO contract amount or 25% of the Reasonable & Customary Amount for the surgical procedure(s). No coverage is available for interns, residents, or facility staff members who assist.
    - **Physician's Assistant -** Charges for services provided by a Regulated Physician's Assistant. Physician's Assistants who actively assist the Surgeon in the performance of a covered surgical procedure will be covered up to the PPO contract amount or 25% of the Reasonable & Customary Amount.
    - **Registered Nurse Practitioner -** Charges for services provided by a Registered Nurse Practitioner.

25. **Prescription Drugs**. Charges for Medically Necessary outpatient drugs that are prescribed in writing by a Physician and are not otherwise excluded by the Plan. So long as the Prescription Drug Card Program is available under this Plan, only outpatient prescriptions obtained with the Prescription Drug Card will be covered. (Drugs covered under the preventive care benefit, compound medications, and injectables that are administered by a Physician and which are not purchased through the Prescription Drug Card will be covered under the Medical provision of the Plan). Off-Label Drug Use may be considered as a Covered Expense when all of the following additional criteria have been satisfied:

    a) The drug is not excluded under the Plan; and
    b) The drug has been approved by the FDA; and
    c) The Plan can demonstrate that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and
    d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or The Compendia-Based Drug Bulletin, recognized it as an appropriate treatment for that form of cancer.

    No prescription drug coverage is provided for any dependent who has primary drug coverage under another Employer sponsored group health plan. See page 29 for specific limitations.

26. **Preventive Care Benefit**. Preventive Care expenses are payable as stated in the schedule of benefits. The preventive care benefit includes the following:
    a) Services with an A or B rating recommended by the United States Preventive

Services Task Force (USPSTF).
b) Immunizations for routine use in children, adolescents, and adults that have a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
d) With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of USPSTF).
e) Prostate screening.

27. **R.N./L.P.N./L.V.N./Midwife/Nurse Midwife/Nurse Anesthetist**. Charges of a registered graduate nurse, practical nurse, or a licensed vocational nurse, who is either licensed as a practical nurse or is registered with an organization having the approval of the medical profession of medical care of Illness or Injury, provided the nurse is not related to the Covered Person either by blood or by marriage, by lineal descent or by any communal relationship; charges for services of a midwife, nurse midwife or nurse anesthetist acting within the scope of his or her license.

28. **Routine Nursery Care -** If you have dependent coverage, your Plan will cover routine nursery care while confined in a Hospital up to but not in excess of four days. This includes nursery care, Physician charges and circumcision for well newborns incurred during the Hospital confinement. Benefits are subject to the normal Plan Deductible and co-insurance limits. **NOTE**: Any charges in excess of four days will not be covered and will not apply to any Deductible or Out-of-Pocket maximums.

29. **Skilled Nursing or Rehabilitation Facility Benefit.** Charges for Medically Necessary services, medicines, and supplies. The daily room benefit for a Skilled Nursing or Rehabilitation Facility cannot exceed the most-common semiprivate rate of the last facility in which you or your dependent was confined prior to confinement in the skilled nursing or rehabilitation facility. Benefits payable will be limited as stated in the schedule of benefits. Eligible expenses must meet the following requirements:

    The Physician must certify that inpatient confinement in an acute care Hospital would be otherwise required and that the Medically Necessary care may not be provided on an outpatient or home health care basis.

30. **Sleep Studies/Sleep Apnea.** Any charges related to the diagnosis or treatment of sleep disorders including sleep apnea, nocturnal seizures, and narcolepsy.

31. **Sterilization Procedures.** Charges for a voluntary sterilization procedure (e.g. tubal ligation or vasectomy) of a covered employee or dependent spouse, but excluding the reversal of these services. Female sterilization procedures may be covered under the Preventive Care Benefit.

32. **Telehealth.** Covered services include a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to:
    a) compressed digital interactive video, audio, or data transmission;
    b) clinical data transmission via computer imaging for teleradiology or telepathology; and
    c) other technology that facilitates access to other covered health care services or medical specialty expertise.

33. **Therapy Services.**.
    a) **Cardiac Rehabilitative Therapy.** Any charges deemed Medically Necessary

provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in an outpatient facility as defined by this Plan.

b) **Chemotherapy**. The use of chemical agents in the treatment and control of disease.
c) **Occupational Therapy**. Occupational therapy by a registered/occupational certified therapist to restore physical function. Benefits are not provided for vocational training, educational services, or materials used in Occupational Therapy. **PRE-CERTIFICATION IS MANDATORY for more than six visits**.
d) **Physical Therapy**. A Physician or licensed physiotherapist must provide services for treatment of an impaired bodily function, such as range of motion, for conditions which are subject to significant improvement through short-term therapy. Massage therapy will be covered when part of a physical therapy treatment program and provided by a licensed Physical Therapist. **PRE-CERTIFICATION IS MANDATORY for more than six visits**.
e) **Radiation Therapy**. Treatment with radioactive substances, including materials and services of technician.
f) **Renal Dialysis Therapy**. Treatment of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
g) **Pulmonary Therapy**. Respiration for the introduction of dry or moist gases into the lungs.
h) **Speech Therapy**. The treatment for the correction of a speech impairment resulting from disease, surgery, injury, congenital anomalies or previous therapeutic processes. **PRE-CERTIFICATION IS MANDATORY for more than six visits**. Speech therapy is covered only for disorders of articulation and swallowing resulting from acute illness, injury, stroke, autism, or cleft palate.

34. **TMJ/Jaw Joint Care.** Any jaw (mandibular) augmentation or reduction procedures, or any procedures, restorations, or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome, myofascial pain syndrome or orthognathic treatment, including the correction of abnormal positioning and relationship of teeth.

35. **Transplants.** Charges incurred for transplant surgery (or for donor charges) will be considered under the following categories to allow for Medically Necessary care and treatment.

TYPE I - to be covered as any other Illness:

- artery or vein transplants
- cornea transplants
- heart valve replacements
- implantable prosthetic lenses in connection with cataracts
- joint replacement
- prosthetic by-pass or replacement vessels

TYPE II - The following transplant procedures will be covered when such surgery is not considered Experimental or Investigational for the diagnosis/condition being treated:

- heart transplants
- pancreas
- heart/lung transplants, same donor
- liver transplants
- kidney transplants
- kidney/pancreas transplants, same donor
- single/double lung transplants

- autologous bone marrow transplants
- allogeneic bone marrow transplants
- other method(s) of stem cell support, by whatever name called.

All other transplants not specifically mentioned in Type I or Type II, which are considered Experimental or Investigational will be excluded. No benefits will be paid for any charges associated with them. This includes, but is not limited to mechanical, artificial, and other than human transplants. A human-to-human organ transplant procedure which is not listed above, but which is not Experimental or Investigational treatment for the diagnosed condition being treated will be covered, subject to all provisions of this Plan.

Covered Organ Transplant Expenses Will Include:

a) Related services and supplies which are listed as Covered Expenses under this Plan. Benefits will be payable subject to the Plan's provisions related to the specific Covered Expense. The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where the covered transplant procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Participant receiving the treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Participant must submit itemized receipts for transportation and lodging expenses. The Plan will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code. Non-covered services for transportation and lodging include the following: (1) child care; (2) mileage within the medical transplant facility city; (3) rental cars, buses, taxis, or shuttle service, except as specifically approved by the Administrator; (4) frequent flyer miles; (5) coupons, vouchers, or travel tickets; (6) prepayments or deposits; (7) services for a condition that is not directly related, or a direct result, of the transplant; (8) telephone calls; (9) laundry; (10) postage; (11) entertainment; (12) interim visits to a medical care facility while waiting for the actual transplant procedures; (13) travel expenses for donor companion/caregiver; (14) return visits for the donor for a treatment of a condition found during the evaluation.

b) Donor Organ Procurement: (1) evaluation and surgical removal of donor organ; (2) transportation of the donor organ; (3) storage costs. If the scheduled transplant is canceled due to the patient's condition or death, and another patient cannot use the organ, procurement benefits will still be paid.

Organ Transplant Exclusions: The Plan will not pay for: (a) services and supplies which are not directly related to the receipt of the organ; (b) artificial or animal organs; (c) the cost of the organ itself; (d) any organ transplant procedure which is Experimental or Investigational for the diagnosis or condition being treated; (e) any expenses when approved alternative remedies are available; (f) any financial consideration to the donor other than for a covered expense which is incurred in the performance of or in relation to transplant surgery; (g) any non-covered expense, as described in the Limitations and Exclusions section of this Plan.

36. **Wig.** The first wig following cancer treatment and one per year is covered.

2. LIMITATIONS AND EXCLUSIONS

These provisions apply to all Benefits payable under the Plan. Benefits will not be payable for any of, but not strictly limited to, the following:

1. **Abortion** - Any charges associated with elective abortion procedures unless such procedures are Medically Necessary to protect the life of the mother, or the pregnancy is the result of rape or incest. However, this exclusion will not apply to medical complications arising from or after a non-covered abortion procedure.

2. **Alternative Treatment -** Charges for acupuncture, hypnosis, aromatherapy, biofeedback, Rolfing, and other forms of alternative treatment as defined by the Department of Complementary and Alternative Medicine of the National Institute of Health.

3. **Alcohol/ Chemical Dependency/ Drug Abuse -** Medications or other prescription drugs used by an Outpatient to maintain an addiction or dependency on drugs, alcohol or chemicals. Also excluded are services, supplies, or other care associated with the treatment of Chemical Dependency in the event the Covered Person fails to comply with the Plan of treatment.

4. **Behavioral Training and Modifications -** Services, supplies, or other care for job training, scholastic improvement, or behavioral problems in the absence of a diagnosed mental Illness or disorder. Also excluded are services, supplies, or other care for non-chemical addictions such as gambling, sexual, spending, shopping and working addictions, co-dependency, or caffeine addiction, milieu therapy, marriage counseling, vocational rehabilitation, sensory integration, educational therapy and recreational therapy, except for adjunct services as part of an inpatient confinement and as required by the Joint Commission on Accreditation of Healthcare Organizations.

5. **Cardiac Rehabilitation - Inpatient** - Charges incurred for services, supplies, or other care provided to an Inpatient solely for cardiac rehabilitation.

6. **Chelation Therapy** - Charges for chelation therapy, except in the treatment of lead or other heavy metal poisoning.

7. **Civil Disturbance/Crime -** Charges incurred as the result of participation in a riot or civil disturbance or while committing or attempting to commit an assault or felony or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion applies whether or not a criminal conviction is entered provided that it is established by the Plan Administrator by a preponderance of the evidence that a crime was committed.

   Charges incurred for care required while incarcerated in a federal, state, or local penal institution or while in custody of federal, state or local law enforcement authorities, including work release programs. Also excluded are any charges incurred due to complications relating to or resulting from these conditions or services.

8. **Cosmetic Services** - Charges incurred for any treatment for cosmetic purposes and/or complications arising directly from the cosmetic services. Cosmetic services means procedures performed to improve a Covered Person's appearance or to correct a deformity without restoring physical bodily function, except as specifically listed under Covered Expenses. The presence of a psychological condition will not entitle a Covered Person to coverage of cosmetic services.

   Excluded services include, but are not limited to, removal of tattoos, scars, wrinkles or excess skin; plastic surgery; silicone injections or implants; electrolysis; hair pieces or hair transplants; treatment of baldness; correction of breast size or disproportion/dissymmetry (except following mastectomy); revision of previous elective procedures; removal of keloids; pharmaceutical regimes; nutritional

procedures or treatments; rhinoplasty; epikeratophakia surgery; skin abrasions performed for the treatment of acne; and surgery to correct or repair the results of a prior surgical procedures in which the primary purpose is to improve appearance even if that prior procedure was a covered service.

9. **Court Ordered Care** – Any care, confinement or treatment provided as a result of a court order.

10. **Custodial Care/Educational Care** - Charges incurred for Custodial Care, or care rendered in rest homes, health resorts, homes for aged or places primary for domiciliary or Custodial Care. Custodial Care means that care which is designed primarily to assist an individual in meeting the activities of daily life, such as help in walking or getting out of bed, personal care such as bathing, dressing, eating, or preparing special diets, or taking medications. Also excluded are charges incurred for education, training, or Room and Board which is provided by an institution which is primarily an institution of learning or training, including treatment for scholastic improvement, vocational training, motor coordination, learning disabilities or behavioral problems. Charges for any expenses for training, educational instruction, or educational materials, unless otherwise specified in the Plan, and charges for services, supplies, or other care for educational or training procedures used in connection with speech, hearing or vision.

11. **Disposable Supplies/Personal Services** - Charges incurred for normal home medical supplies, first aid items, or over the counter supplies provided to an outpatient, including but not limited to, ace bandages, and elastic stockings. Also excluded are charges for services or supplies which constitute personal comfort or beautification items, television or telephone use, or rest cures. This exclusion does not apply to surgical dressings and supplies, surgical hosiery, compression hosiery and pressure garment, and stump socks as listed under covered expenses.

12. **Donor Charges -** Charges incurred for any services, supplies, or other care which are rendered to any person who requires them by reason of acting as a donor of any non-covered organ or element of the body, or services or supplies rendered to any individual who is not a covered Participant, except as provided under the donor procurement provision.

13. **Drugs** - Drugs, except insulin, which could be purchased without a written prescription. (So long as the Prescription Drug Card Program is available under this Plan, out-patient prescription drugs are excluded except as provided under the Prescription Drug Card Benefit, or for the first 30 days of enrollment or after the Prescription Drug Cards have been distributed, whichever occurs first, unless otherwise stated). No prescription drug coverage is provided for any dependent who has primary drug coverage under another Employer sponsored group health plan.

14. **Durable Medical Equipment** - Durable Medical Equipment that does not meet the requirements as stated under covered expenses. Examples include, purchase or rental of escalators or elevators; spas or saunas; blood pressure kits; penile implants; modifications to a home or place of business, such as ramps, air conditioners, seat lift chairs, or supplies for any of these items; adjustments made to vehicles, air purifiers, humidifiers, stair-glider, Emergency Alert equipment, handrails, heat appliances, waterbeds, whirlpool baths, hydrocollators, hot packs, diathermy, infra-red, Hubbard Tank, cold packs, ice packs, and contrast baths.

15. **Employment-Related Conditions /Workers' Compensation -** Charges incurred as the result of or in connection with any activity pertaining to any act of employment for profit, gain, or compensation for which you receive a W-2 or 1099 from an Employer, or for which you file a self-employment schedule for federal income taxes; or charges

incurred as the result of a disease, Illness, or condition for which benefits are payable under any Workers' Compensation Act, any Occupational Diseases Act or any other similar such benefit program. If Workers' Compensation benefits are not available to you, then this exclusion does not apply. This exclusion applies whether or not you claim the benefits or compensation.

16. **Exercise Equipment/Health Clubs** – Exercise equipment, massage or vibratory equipment, swimming or therapy pools, enrollment in health, athletic or similar clubs, or services, or supplies used for physical fitness, athletic training, or general health upkeep.

17. **Experimental/Investigational Services** - Charges for services, supplies or other care which are considered Experimental or Investigational as defined by this Plan (including organ transplant or mechanical organ implantation, except as provided under the transplant provision of this Plan). (Please refer to the definition of Experimental/ Investigational.)

18. **Family Member/Resident Provider** - Charges incurred for services, supplies or other care rendered by a Provider who is a member of the Covered Person's immediate family, or who resides in the Covered Person's household. Immediate family includes you, your Spouse, child, brother, sister, parent, or in-law of you or your Spouse.

19. **Genetic Testing** – Genetic testing and counseling that is without medical necessity.

20. **Governmental Health Plans –** Services furnished to the Covered Person under any government program or in any veterans Hospital, military Hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. This exclusion does not apply to treatment of non-service related disabilities or for inpatient care provided in a military or other Federal Government Hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

21. **Gynecomastia** - Surgical treatment of gynecomastia.

22. **Hazardous Material** – Expenses incurred as a result of radioactive contamination or the hazardous properties of nuclear material.

23. **Hearing Related Services** - Charges incurred for routine hearing tests (except as covered under the preventive care benefit), hearing aids or the fitting of hearing aids (except as otherwise stated). However, hearing tests performed in connection with a disease, illness, or injury are covered.

24. **Hospice Care** - Hospice care benefits are not payable for: services provided by persons who do not regularly charge for their services; counseling which is not provided as part of the hospice care plan; services provided by homemakers, caretakers and the like; funeral expense; or treatment intended to cure the terminal Illness.

25. **Human Growth Hormone** - Human growth hormone for children born small for gestational age. It is only a covered service in other situations when allowed by the administrator, on behalf of the Employer, through prior authorization.

26. **Hyperhidrosis -** Treatment of hyperhidrosis (excessive sweating).

27. **Infertility/Fertility** - Charges incurred for fertility or infertility studies or treatment including but not limited to: artificial insemination, in vitro fertilization, hormone therapy to cause pregnancy, embryo therapy, embryo transport, gamete intra-Fallopian transfer, gamete/zygote embryo transfer, donor semen or eggs, gamete transfer, HLA typing (human leukocyte antigen), sperm banking, other assistive reproductive services, or reversal of elective sterilization procedures, and charges related to surrogate pregnancies.

28. **Maintenance Care** - Treatment given when no additional progress is apparent or expected to occur. Maintenance care includes treatment that preserves the present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

29. **Massage Therapy** - Charges for massage therapy (except as provided under physical therapy).

30. **Maternity Related Expenses** - Charges incurred for any ultrasound, echogram, or amniocentesis procedures related to pregnancy unless such procedure is necessitated by a complication of pregnancy. Testing for the purpose of fetal age or sex or solely because of maternal age shall not be considered a complication of pregnancy. Exception: One routine ultrasound per pregnancy will be considered a covered expense.

31. **Mental and Emotional Conditions/Chemical Dependency** - Charges for services or supplies provided by or at a residential care facility or halfway house.

32. **Military Service/War Injuries -** Charges incurred as a result of military service for any country or organization, including service with military forces as a civilian whose duties do not include combat. Charges incurred for treatment of injury, Illness or other condition which is occasioned by war, declared or undeclared.

33. **Motor Vehicle Accidents** - Charges incurred due to injuries received in an accident involving any motor vehicle for which there is in effect, or is required to be in effect, any policy of no-fault insurance. This exclusion is not applicable to expenses not paid by any required policy of no-fault insurance as a result of state required policy Deductibles or maximums.

34. **Newborn Care** - Charges incurred for usual and ordinary inpatient nursery and pediatric care of a well newborn child except those charges incurred during the length of the mother's stay, not to exceed 4 days.

35. **Non-Covered/Non-Medical Services -** Charges incurred for any services, supplies, or other care which is not specifically listed as covered expenses under this Plan.
    a) Charges incurred due to complications resulting from any treatment, services or supplies which are specifically excluded under this Plan.
    b) Charges incurred for any services, supplies or other care for personal hygiene, environmental control, or convenience items, or charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form, charges for medical records and reports, or charges for travel or accommodations, whether or not recommended by a Physician.
    c) Charges for benefits that are not payable due to the application of any specified Deductible or co-payment provisions contained herein
    d) Charges by a non-covered Provider
    e) Charges incurred before coverage began or after coverage terminated, or which are in excess of the limits specified in the Plan.

36. **Non-Emergency Care** - Care received in an emergency room which is not emergency care. This includes, but is not limited to suture removal in an emergency room.

37. **Non-Timely Claim Submission** - Charges submitted more than **one year and 90 days** after the charges were incurred or information necessary to process the claim was first requested from the Covered Person. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

38. **No Obligation To Pay Services -** Charges incurred for which the Covered Person has no legal obligation to pay in the absence of this or similar coverage, or for which no charge has been made. Where Medicare coverage is involved and this Plan is a secondary coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts. Any benefit payment issued under the Plan that is not cashed by the payee within the 12 month period immediately following its date of issue will be considered void and will only become a Plan liability upon receipt of the Employee's written request for re-issuance. Such request must be made within the 24 month period immediately following the date the benefit payment was issued. Any request that is filed later will be denied.

39. **Not Medically Necessary** - Charges for services, supplies or other care which are not Medically Necessary for the diagnosis or treatment of a physical or mental Illness, injury, or symptomatic complaint (Please refer to the definition of Medically Necessary.); or,
    a) Services, supplies, treatment, or any care which is not rendered for the treatment and correction of a specific Illness, or condition, or accidental bodily injury, or which is incurred while the Covered Person is not under the direct care of a Physician; or,
    b) Hospital care and services rendered after the patient has been discharged from the Hospital by the attending Physician, or for Hospital care and services when a registered bed patient is absent from the Hospital; or,
    c) When in the judgment of the Administrative Manager (or such person, persons or group designated by him) the medical or surgical services did not require the acute Hospital overnight setting, but could have been provided in a Physician's office, the outpatient department of a Hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered, including but not limited to admissions primarily for observation or evaluation and/or diagnostic studies that could have been provided safely and adequately on an outpatient basis, or admissions to control or change the patient's environment.
    d) The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a covered expense even though it is not specifically listed as an exclusion.

40. **Nutritional Services** - Charges incurred for food supplements (except enteral or total parenteral nutrition), minerals, vitamins, or other dietary supplements on an outpatient basis, except as covered under the preventive care benefit.

41. **Obesity** - Charges incurred for services, supplies, surgery, or other care or programs rendered for the purpose of weight loss, regardless of its classification, even if the individual has other health conditions which might be helped by weight reduction (except as covered under the preventive care benefit), or charges incurred for the removal of excess fat or skin following weight loss or reversal of any surgical treatment of morbid obesity.

42. **Oral Surgery -** Charges incurred for any treatment of teeth or gums or for any treatment in connection with the fitting or wearing of full or partial dental prostheses (fixed or removable), unless otherwise specified in the Plan.
    This exclusion does not apply to:
    a) Excision of tumors or cysts or incision or drainage of an abscess or cyst;
    b) Treatment of accidental injury to natural teeth (including their replacement), provided treatment is completed within 12 months of the injury (breaking or chipping of a tooth while eating is not considered an accident);
    c) Hospital services may be covered provided such services are Medically Necessary to safeguard the health of the Covered Person from the effects of a dental procedure due to a specific non-dental organic impairment.

43. **Outside United States -** Charges incurred outside the United States except for illness or injury incurred while travelling for business or pleasure.

44. **Physical Exams/Immunizations** - Charges for immunizations or other care for routine physical examinations unless specified under Covered Expenses. Exams and tests for screening purposes or which are required by third parties such as; for employment, licensing, travel, insurance, marriage, adoption, or services conducted for medical research, or an examination required by a court.

45. **Physicians' Visits/Stand-by Charges** - Charges incurred for inpatient Physicians' visits in excess of one each day if surgery is not required, or for Physicians' visits on or after the day of surgery, unless there is more than one diagnosis being treated; charges for services by a covered practitioner which are not within the scope of his/her license; or, stand- by charges by a Surgeon or pediatrician.

46. **Podiatry (routine)** – Services and supplies for the removal of bunions (except by capsular or bone surgery), toe nails (except for surgery for ingrown nails), corns or calluses or the trimming of toenails, unless needed in treatment of a metabolic or peripheral vascular disease, and treatment of weak, strained, flat, unstable or unbalanced feet.

47. **Reasonable and Customary Charges** - Charges which exceed the Reasonable and Customary Amount or which are excessive. Please refer to the Plan's definition of Reasonable and Customary Amount.

48. **Sexual Transformation/Sexual Dysfunction** - Charges incurred for services, supplies, or other care related to sex transformation, sexual dysfunctions, inadequacies, or charges related to impotency, including penile implants.

49. **Standard Medical Treatment** – Services and supplies provided for any operation, procedure, treatment, facility, drug, device or supply not generally accepted as standard medical treatment under the professional standards of medical practice for the condition being treated at the time incurred for the geographic location of the principal office of the Company, or any items requiring United States federal or other United States governmental agency approval which approval has not been granted as of the time services are provided.

50. **Sterilization reversal charges** – Charges incurred in connection with surgical procedure to reverse (a) a vasectomy or (b) a sterilization tubal ligation.

51. **Third Party Responsibility -** Charges which are or which may become the responsibility of any third party. However, the Administrative Manager has been authorized by the Plan to pay provisional benefits when the beneficiary and their legal counsel, if any, have executed a Subrogation Agreement form which is

satisfactory to the Administrative Manager. Refer to the Plan provisions regarding Subrogation of Benefits and Right of Recovery.

52. **Varicose Veins** - Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method is also excluded.

53. **Vision Care** - Vision examinations (except as covered under the preventive care benefit) or testing for the purposes of prescribing corrective lenses; orthoptic training (eye exercises); radial keratotomy, refractive keratoplasty or any other surgery or procedure to correct myopia, hyperopia or stigmatic error; or the purchase or fitting of eyeglasses or contact lenses (except as otherwise stated).

SHOULD THE PLAN PAY BENEFITS AND IT IS LATER DETERMINED THAT SUCH BENEFITS SHOULD NOT HAVE BEEN PAID BASED ON THE EXCLUSIONS MENTIONED ABOVE OR OTHER TERMS HEREIN, THE PLAN EXPLICITLY RESERVES THE RIGHT TO RECOVER ANY AND ALL BENEFITS PAID IN ERROR. YOU, YOUR BENEFICIARY, OR A DULY AUTHORIZED REPRESENTATIVE MAY APPEAL ANY DENIAL OF A CLAIM FOR BENEFITS BY FILING A WRITTEN REQUEST FOR REVIEW TO THE PLAN ADMINISTRATOR WITHIN 180 DAYS AFTER RECEIPT OF THE WRITTEN NOTICE OF DENIAL OF A CLAIM. PLEASE REFER TO THE CLAIMS REVIEW AND APPEAL PROCEDURES UNDER SECTION X. OF THE PLAN.

B. PRESCRIPTION DRUG CARD BENEFIT

The prescription drugs listed below are payable for outpatient prescription drugs obtained with a drug card or through the mail order program only.

Prescription drugs are drugs and medicines lawfully obtainable only upon the written prescription of a Physician and include the following covered drugs:

- Federal Legend Drugs
- State Restricted Drugs
- Compounded Medication
- OTC Diabetic Supplies
- Insulin
- Needles and Syringes on Prescription for diabetics only
- Retin-A (up to age 25 only)
- Medications recommended by the HRSA and USPSTF, including contraceptives
- Smoking deterrents, including over the counter drugs

The following are <u>excluded</u> from coverage unless specifically listed above as a covered drug:

- Non-Federal Legend Drugs
- Therapeutic devices or appliances
- Fertility medications
- Allergy Serum
- Anti-obesity drugs
- Anorexiants
- Human Growth Hormone for children born small for gestational age. It is only covered in other situations when allowed by the Plan through prior authorization.
- Drugs for treatment of Onchomycosis (toenail fungus)
- Legend Vitamins or Fluoride Products (except those recommended by the HRSA and USPSTF and prenatal vitamins)

- Medications related to sex transformation, sexual dysfunctions or inadequacies, sexual enhancement
- Drugs whose sole purpose is to promote or stimulate hair growth.
- Drugs labeled "Caution-limited by Federal Law to investigational use", or an experimental drug, even though a charge is made to the individual.
- Medications which are not approved by the Federal Drug Administration (FDA).
- Medication for which the cost is recoverable under any Worker's Compensation or Occupational Disease law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, Skilled Nursing Facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals, as these charges are covered under the Medical provision of the Plan or are otherwise excluded.
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.

Dispensing Limits:

- **Mail Service:** The amount of drug including Insulin which is to be dispensed per prescription or refill will be in quantities prescribed up to a 90 day supply. One Year of Refills is covered.
- **Retail:** The amount of drug (including Insulin) which is to be dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply. One year of refills is covered.

Benefits are subject to the co-payments as outlined in the Schedule of Benefits. No prescription drug coverage is provided for any dependent who has primary drug coverage under another Employer sponsored group health plan. The Prescription Drug Card portion of the Plan does not coordinate benefits with a primary or secondary payor.

C. DENTAL EXPENSE BENEFITS - OPTIONAL

Calendar Year Deductible*

Per individual.....$25.00
Per family $75.00

*Deductible applies to Class B & C Services

Calendar Year Maximum:

Class A, B, and C combined $1,500.00
Class D.....$500.00

% Payable

Class A – Preventive.....100%
Class B – Basic 80%
Class C – Major.....50%
Class D – Orthodontia.....50%

COVERED DENTAL EXPENSES

Covered Dental Expenses included hereunder are the charges of a licensed dentist which the Covered Employee is required to pay for the following dental services and supplies received, while covered:

Class A – Preventive Procedures

1. Routine oral examinations, but not more than twice during any calendar year.
2. Topical application of fluoride but not more than once during any calendar year.
3. Space maintainers for unerupted teeth and following extraction of primary teeth limited to once per lifetime for children up to the age of 16. Allowance includes all adjustments within 6 months after installation.
4. Panoramic x-rays, including full mouth x-rays, but not more than once in any five (5) year period.
5. Supplementary bitewing x-rays, limited to two sets in any calendar year; and such other dental x-rays required in connection with the diagnosis of a specific covered condition which requires treatment.
6. Prophylaxis (cleaning of teeth), but not more than twice in any calendar year.
7. Topical application of sealant applicable only to permanent molars once during a three (3) year period for dependent children under age 16.
8. Consultation with specialist.

Class B – Basic Procedures

1. Extractions
2. Oral Surgery
3. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration to restore diseased or fractured teeth.
4. Surgical incision and drainage of dental abscess
5. Surgical exposure to aid eruption
6. Excision of hyperplastic tissue
7. Periodontal appliance.
8. Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures). Limited to once per quadrant every 24 months.
9. Antibiotic drug injection
10. Biopsy of oral tissue
11. Palliative treatment. Covered as a separate procedure only if no other service (except x-rays) is provided during the visit.
12. Problem focused exams.
13. Bacteriologic culture
14. Histopathologic examination
15. General anesthesia (including IV sedation and local anesthetic when medically necessary) when administered in connection with oral or dental surgery.
16. Treatment of periodontal or other diseases of the tissues of the mouth.
17. Periodontal maintenance procedures.
18. Periodontal Surgical Procedures.
19. Endodontic treatment, including root canal therapy.
20. Pin retention limited to once per tooth in any 12 month period (regardless of the number of pins per tooth). Pin retention must be performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
21. Sedative filing limited to once per tooth in any 24 onth period.
22. Alveoloplasty
23. Vital pulpotomy.

Class C – Major Procedures

1. Recementing of crowns, inlays, onlays, or bridgework.
2. Repairs to complete or partial denture, bridge, or crown.
3. Stainless steel crown
4. Relining or rebasing complete or partial dentures.
5. Tissue conditioning.
6. Denture adjustment.
7. Inlays and onlays. Inlay or onlay restorations are covered only if the tooth cannot be restored by a filling and (for replacements).

8. Crowns (single restorations only). Crowns are covered only if the tooth cannot be restored by a filling. Crowns for the primary purpose of splinting, altering, or maintaining vertical dimension, or restoring occlusion are not covered. For persons under 16 years of age, the benefit for crowns on vital teeth is limited to resin or stainless steel crowns.
9. Cast post and core.
10. Steel post and composite or amalgam.
11. Fixed bridges – initial placement or replacement. Replacement is provided if the existing bridge is five years old or older and cannot be made serviceable.
12. Complete or partial dentures – initial placement or replacement. Covered charges for complete or partial dentures do not include any additional charges for over dentures or for precision or semi precision attachments.
13. Implants. Surgical placement of implants, implant supported prosthetics, maintenance and repair or removal. Implants are limited to once per tooth in any 10 year period.

Class D – Orthodontia
Coverage is provided for orthodontic treatment. Formal, full-banded retention and treatment, including x-rays and other diagnostic procedures, and removable or fixed appliances for tooth or bony structure guidance or retention, are covered. Benefits are payable when a covered expense is incurred.

The term "dentist" means a dentist practicing within the scope of his license. For purposes of this Benefit, the term "dentist" also includes a Physician authorized by his license to perform the particular dental services he has rendered.

ADDITIONAL PROOF OF CLAIM

The Plan may require as proof of claim a complete dental chart showing any extractions, fillings or other work performed prior to the date of the loss for which the claim is being made: itemized bills of the dentist or Physician or other sources of services, supplies, and treatment; x-rays, laboratory or Hospital reports, casts, molds, or study models, or other similar evidence of the condition or treatments of the tooth or mouth.

DENTAL EXCLUSIONS

"Covered Dental Expenses" do not include and no benefits are payable for:
1. Treatment by other than a licensed dentist or Physician except charges for cleaning of teeth performed by a licensed dental hygienist under the supervision and direction of a dentist.
2. Dental Services furnished without charge or paid by a government unit, Employer, benefit association, union or similar group.
3. Dental Services and supplies which are given solely for cosmetic purposes.
4. Charges for replacement of a lost or stolen prosthetic device.
5. Charges in connection with any accidental bodily injury or sickness arising out of or in the course of employment or which is compensable under any Workers compensation or Occupational Disease Act or Law.
6. Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the Person was not covered under the Plan, or which were ordered while the Person was covered under the Plan but are finally installed or delivered to such Person more than thirty days after termination of coverage.
7. Expenses for services or supplies which are furnished, paid for or otherwise provided in a U.S. Government Hospital or any other Hospital operated by a government unit (unless a charge is made that the Covered Person is legally required to pay without regard to the existence of coverage).
8. Covered dental charges shall not include the portion of any charge that exceeds the Reasonable and Customary Amount. Such Reasonable and Customary Amount

shall be the charge that is not higher than the usual charge made by the Provider for the service or supply and that does not exceed the usual charge made by most Providers of the same service or supply within the same area. The Plan has the discretionary authority to determine whether a charge is Reasonable and Customary. Such determination will consider the nature and severity of the condition being treated, any medical complications, and any unusual circumstances that would require more time, skill or expertise.

9. Harmful habit appliances.
10. Replacement of fixed or removable prosthesis, crowns, inlays, onlays and laboratory fabricated restorations, if replacement occurs within five years of the original placement.
11. Any services related to the jaw joint (temporomandibular joint or TMJ).
12. Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
13. Teeth lost prior to coverage under this Plan are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible nature teeth lost during the term of this coverage.
14. Charges which are not specifically listed as covered expenses.
15. Any expenses which would be excluded under any limitation or exclusion in the Comprehensive Medical Expense provision of the Plan.

Any dental expenses which are considered Covered Expenses under the medical benefits provision of this Plan shall not be considered as "Covered Dental Expenses" hereunder.

D. VISION CARE BENEFITS - OPTIONAL

Calendar Year Deductible ..... None
Percent Payable 100%

Vision care benefits are payable for Covered Vision Care Expenses, subject to the limitations listed below, when services and/or supplies are recommended by a Physician or an Optometrist.

Covered Vision Care Expenses

Vision Exam.....$10 co-pay

Prescription lenses (including factory scratch coating polycarbonate lenses for children under 19 years old and photochromic lenses for children under 19 years old):
Single vision, bifocal, and trifocal (pair). .....$20 co-pay

Frames.....$0 co-pay up to $130.00

Contact Lenses:
Non-Elective .....$0 co-pay
Elective.....$0 co-pay up to $130.00

NOTE: If contact lenses are chosen, no benefits will be available for eyeglass lenses and frames in that period. Contacts are available in lieu of glasses.

Frequency Limitation

Vision Exam.....Once every 12 months

Prescription lenses or contact lenses, or
12 months supply of disposable contact lenses. .....Once every 12 months

Frames..... Once every 24 months

Excluded Vision Care Expenses

1. Medical or surgical treatment of an eye injury or eye disease

2. Charges covered under any other provision of this Plan

3. Any expenses, other than Vision Care, which are excluded or limited under the Comprehensive Medical Benefits provision of this Plan

4. Charges for orthoptics (eye muscle exercises), vision training or subnormal vision aids

5. Charges for lenses which can be purchased without a prescription

6. Sunglasses and safety glasses

IV. DUPLICATION OF BENEFITS

A. COORDINATION OF BENEFITS

Benefits provided under this Plan are subject to this Coordination of Benefits (COB) provision. This Provision shall apply to all benefits provided under this Plan, except for benefits provided under a Prescription Drug Card Benefit of this or any other Plan, other than as required by law for claims subject to Medicare Part D and Medicare secondary payor requirements. No prescription drug coverage is provided for any dependent who has primary drug coverage under another Employer sponsored group health plan.

The intent of COB is to avoid a duplication of benefits when an individual has coverage under more than one Plan. In such an instance, the two (or more) Plans will determine between them which Plan will provide benefits on a “primary” basis and which Plan will provide benefits on a “secondary” basis.

1. DEFINITIONS

a. The term “Plan” as used in this provision refers to any Plan, policy or coverage providing benefits or services for or by reason of health, medical, dental or vision care or treatment. Such Plans may include, without limitation:

   (1) Group coverage, whether insured or uninsured, including but not limited to Hospital indemnity benefits and Hospital reimbursement type Plans;
   (2) Blue Cross and Blue Shield group coverage and other group pre-payment Plans;
   (3) Labor/management trustee Plans, union welfare Plans, Employer organization Plans, and Employee benefit organization Plans;
   (4) Coverage under governmental programs or any coverage required by statute, excluding Medicaid;
   (5) Group or individual automobile insurance;
   (6) Homeowners or any other medical payment reimbursement plan;
   (7) Does not include individual (or individual’s family) insurance contracts.

b. "ALLOWABLE EXPENSES" means any necessary, reasonable and customary item of expense, at least a portion of which is covered under this Plan.

   When this Plan is secondary, “Allowable Expense” shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a Provider of service in which such Provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the Provider’s contracted amount and the Provider’s regular bill charge.

   When a Plan provides benefits in the form of services 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.

c. "CLAIM DETERMINATION PERIOD" means calendar year.

2. WHEN THIS PLAN IS SECONDARY

a. When there is a basis for a claim under this Plan and under another Plan, this Plan will be a secondary Plan under which benefits are determined after benefits of the other Plan, unless: The other Plan has rules coordinating its benefits with the benefits of this Plan, and both the rules of the other Plan and the Order of Benefits Determination of this Plan do not agree. In those cases, each Plan will be responsible equally for benefits payable.

If this Plan is the secondary Plan, benefits payable under this Plan will be the lesser of the amount this Plan would have paid had it been the primary Plan, or a reduced amount, if any, that when added to the benefits payable by the other Plan(s) will not exceed the Allowable Expenses. Benefits payable under any other Plan(s) include the benefits that would have been payable had a claim been duly made.

3. ORDER OF BENEFIT DETERMINATION

a. This Plan determines its order of benefits using the first (in sequence) of the following rules that is applicable:
   (1) A Plan without a coordinating provision will always be the primary Plan;

   (2) The benefits of a Plan which covers the recipient of covered services other than as a dependent will always be the primary plan;

   (3) Child of Parents Not Separated or Divorced. - Primary of the Plans covering dependent children will be determined on a "gender neutral" basis. The Plan covering the dependent child of the parent whose birth date (month and day) occurs first in the calendar year will be primary. This is called the "birthday rule". If both parents have the same birthday, the Plan which covered the parent longer will be the primary Plan.

   (4) Child of Separated or Divorced Parents. - If two or more Plans cover a child of divorced or separated parents, benefits for the child are determined in this order:
      (a) first, the Plan of the parent with custody of the child;
      (b) next, the Plan of the Spouse of the parent with custody of the child;
      (c) next, the Plan of the parent not having custody of the child; and
      (d) finally, the Plan of the Spouse of the parent not having custody of the child.

      However, if the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide benefits of the Plan of that parent has actual knowledge of those terms, such Plan will be the primary Plan.

   (5) Active/Inactive Employee - the benefits of a Plan which 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 which covers that 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 benefits, both Plans will have equal responsibility for payment of benefits.

   (6) Longer Length of Coverage. - If none of the above rules determines the order of benefits, the benefits of the Plan which covered the recipient of covered services longer are determined before those of the Plan which covered such person for the shorter time.

b. When the provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

c. Regardless of the order outlined above, in the event a covered person is injured in any way due to an accident, and any no-fault, personal injury protection (“PIP”) and/or medical payments coverage(s) are found to be available, these first party coverages are primary and must be paid out (exhausted) in there entirety before a payment under this Plan is to be considered eligible.

4. COORDINATION WITH MEDICARE

The Medicare Secondary Payer regulations provide special rules regarding the order of benefits determination for persons who are covered under Medicare. In general, these regulations provide:

a) If the active Employee (or their dependent), is age 65 or older, Medicare is secondary to Plans of Employers with at least 20 Employees.
b) If a retiree or spouse of a retiree is age 65 or older, Medicare is primary to the Plan.
c) If the claimant has kidney failure and is receiving dialysis, Medicare is secondary to the Plans of all Employers for the first 30 months, regardless of the number of Employees.
d) Different rules apply if you or your covered dependent becomes eligible for Medicare coverage due to a disability other than End-Stage Renal Disease (ESRD). In such case, the order of benefits determination will be based upon the current, applicable Medicare Secondary Payer regulations.

Active employees who are also Medicare beneficiaries are free to elect Medicare as their primary payer. However, if they do so there is no coverage available under this Plan. Important note: If a Medicare-eligible Employee elects Medicare as primary, no Plan coverage will be available for any of his dependents.

If active employees who are also Medicare beneficiaries elect medical coverage under this Plan, this Plan will be primary. This Plan will pay its benefits first, and then the claims may be submitted to Medicare for consideration.

For retirees and their spouse, age 65 and older, Medicare is the primary carrier. Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage. If such person fails to enroll in Medicare coverage, benefits will be payable as if Medicare is in effect.

B. HEALTH MAINTENANCE ORGANIZATION

If you are a member of a Health Maintenance Organization (HMO) qualified under Section 1310 of the HMO Act of 1973 sponsored by this Employer and join this Plan, coverage becomes effective the day following termination of coverage under the HMO.

If you are covered by this Plan and join an HMO sponsored by this Employer, coverage under this Plan terminates the day preceding membership in the HMO.

C. STATE MEDICAL ASSISTANCE PROGRAM

The Plan will not limit or exclude the benefits payable by the Plan due to a person being covered by a State Medical Assistance Program.

Benefits will be paid to the State or state agency and will be paid up to the cost of medical expenses paid by the state through medical assistance. Benefits paid to the state will not be more than the benefits to which the Covered Person is entitled under the Plan.

D. SUBROGATION AND RECOVERY

1. EXCLUSION OF BENEFITS AND ASSIGNMENT

Benefits are not payable for injury (ies) or Illness(es) to you or your dependent to which a third party(ies) may have caused or contributed. However, the Plan may elect, in its sole discretion, to advance payments for medical expenses incurred for any injury(ies) or Illness(es) to you or your Dependents to which a third party(ies) may have caused or contributed. By accepting payment of medical treatment by the Plan for any injury(ies) or Illness(es) to which a third party(ies) may have caused or contributed, you or your dependent assign(s) to the Plan all his or her rights to any recovery from any source in an amount equal to the amount advanced for you or your dependent's injury(ies) or Illness(es).

As assignee, the Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you of your dependent's injury(ies) or Illness(es) up to the amount advanced, regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The made whole doctrine shall not apply to the Plan's right of assignment. The Plan's right of assignment is a right of first reimbursement and takes priority over any person's interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan's right of assignment shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising its right of assignment, the Plan may exercise its right of subrogation and/or reimbursement as stated below.

2. SUBROGATION OF BENEFITS

If payments are made under this Plan for any treatment or service because of injury to, or sickness of, a covered individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier or uninsured motorist coverage) for indemnification, damages or other payment with respect to such injury or sickness, then:

a) The Plan shall be subrogated, to the extent of the payments made under this Plan, to the rights of the covered individual to receive or claim such indemnification, damages or other payment.
b) The covered individual and their legal counsel, if any, shall execute or secure the execution of such instruments as the Plan may reasonably require to enforce its rights hereunder; and
c) Any individual who shall receive payment from any such third party or parties because of injury to, or sickness of, a covered individual shall first reimburse the Plan (before reimbursing any third parties) from such payment so received (but not in excess of the amount received) for all payments made, past, present, and future under this Plan for treatment or service with respect to the same injury or sickness.
d) Such first reimbursement shall be made to the Plan, without set-off for attorney fees or any other costs or expenses and without regard to whether the covered individual has been "made whole" for his/her damages and the Plan shall hold an automatic first priority lien upon the proceeds of any reimbursement payment or recovery until it receives full reimbursement.
e) Should the covered individual fail to reimburse the Plan first from any such payment received, the Plan may file suit to recover, and the covered individual will be solely responsible for any court costs in connection with such suit.

The Participant is required to submit a Subrogation Agreement provided by the Plan

office which has been signed by the Participant, beneficiary if applicable, and their legal counsel, if any, as a necessary part of Proof of Loss for a claim involving a third party action. Failure to submit such signed agreement may cause payment of the claim to be delayed until the third party action is resolved or disallowed due to failure on the part of the Participant to provide adequate Proof of Loss. The payment of benefits by the Plan without a Subrogation Agreement shall not diminish or nullify the Plan's rights of subrogation and/or reimbursement. **Under no circumstances will the Plan share in or assume liability for any legal fees or any other costs and expenses incurred by the covered individual in connection with any third party claim, and its rights of Subrogation and First Reimbursement shall not be subject to the "Make Whole" doctrine, or similar doctrine, under state law or federal common law.**

3. REIMBURSEMENT

If you or your dependent recovers from any source any amount for any injury(ies) or Illness(es) for which the Plan advanced medical payments, you or your dependent shall reimburse the Plan an amount equal to the amount advanced or the amount of you or your dependent's recovery, whichever is lesser. The Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you or your dependent's injury(ies) or Illness(es), regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The make whole doctrine shall not apply to the Plan's right of reimbursement.

The Plan's right of reimbursement is a right of first reimbursement and takes priority over any person's interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan's right of reimbursement shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising our right of reimbursement, the Plan may exercise our right of assignment and/or subrogation.

4. COOPERATION

You or your dependent and your legal representative must cooperate fully with the Plan in asserting the Plan's recovery rights under sections 1- 3. You and your dependent and your legal representative shall, upon request, provide all information and sign and return all documents requested by the Plan in enforcing the Plan's rights under this Plan. If you, your dependent and/or your counsel refuse to cooperate or pay over any funds due to the Plan under this Article, or adversely prejudice the Plan's rights by any act or omission, the Plan Administrator may, in addition to the other rights set forth herein:

a) Offset and reduce any future benefits that may be payable to you or any of your covered dependents, whether or not related to the incident giving rise to the Plan's right of subrogation and/or reimbursement, to the extent of the Plan's right of recovery; and/or
b) Terminate participation of you and your dependents, if any, under the Plan on a date established by the Plan Administrator, without any further rights to benefits hereunder. In the event of the termination of your and your dependent's participation under the Plan, it shall not constitute a COBRA qualifying event.

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.

5. LIABILITY AND ATTORNEY'S FEES

If you or your dependent or your legal representative fails to cooperate with the Plan in enforcing our rights under this Plan or recovers from any source any amount for any injury(ies) or Illness(es) for which the Plan advanced medical payments and fails to immediately reimburse the Plan for the total amount advanced, you or your Dependent and your legal representative shall be jointly and severally liable to the Plan in an amount equal to the amount advanced plus reasonable attorney's fees and court cost incurred by the Plan in enforcing our rights under this Plan. These rights are in addition to any rights the Plan may have against any other party(ies).

V. GENERAL PROVISIONS

A. THE PLAN

1. **PLAN CONSTRUCTION.** The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

2. **CONFORMITY WITH LAW**. Notwithstanding any other provision to the contrary, this Plan Document is held to be in compliance with P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), with P.L. 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1995 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA); and with any applicable regulations. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto. The Plan has been amended to comply with the Patient Protection and Affordable Care Act (PPACA) and regulations issued thereunder. The Plan Administrator will administer the plan in good faith compliance with PPACA and regulations issued from time to time thereunder.

3. **PLAN IS NOT A CONTRACT.** This Plan shall not be construed as a contract, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Employee to continue or terminate employment at any time.

4. **PLAN DESCRIPTION**. The Plan Administrator shall provide to Employees who are Covered Persons a Plan Document and Summary Plan Description containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

5. **CHANGES TO PLAN**. This Plan may be changed by the execution of an amendment to this Plan by the Plan Administrator at any time without prior notice to or the consent of any Covered Person or of any person entitled to receive payment of benefits under the Plan. The Plan Administrator shall provide to the covered Employees a summary of any material change to this Plan 60 days prior to such change.

6. **TERMINATION OF PLAN**. The Plan Administrator may terminate this Plan at any time by providing written notice to the Covered Employees. Such termination will become effective on the date set forth in such notice.

7. **WRITTEN NOTICE**. Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

8. **WAIVER**. The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

9. **CLERICAL ERROR/DELAY**. Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the

Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an adjustment of any such contributions may be made.

10. **WORKER'S COMPENSATION.** This Plan does not replace, nor does it affect, any requirement for coverage by worker's compensation insurance.

B. MISSTATEMENTS

If any relevant fact has been intentionally misstated or fraudulent by or on behalf of any person to obtain or maintain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such intentional misstatement or fraud, termination of coverage shall be effective retroactive to the date of such misstatement. The Plan will provide 30 days advanced written notice before rescission of coverage.

Each Participant and/or beneficiary have/has an affirmative requirement to disclose any material fact that would affect that Participant's or his beneficiary's eligibility for participation or benefits. The failure to inform as soon as administratively possible shall be deemed to be an intentional misrepresentation and coverage shall be retroactively terminated (subject to the 30 day notice).

C. LEGAL PROCEEDING

Legal action to recover any lost benefits under this Plan may not be brought prior to the expiration of 180 days after Proof of Loss has been filed in accordance with the requirements of the Plan nor until the Plan's appeal procedure, including utilization of a professional/peer review committee, has been exhausted, and not later than two (2) years after the final claim denial. See also "Claims Review and Appeal Procedures." If you fail to timely appeal, you cannot bring a lawsuit because you did not exhaust your administrative appeal rights.

D. PHYSICAL EXAMINATION

The Administrator, at its own expense, will have the right and opportunity, while claim is pending, to examine any individual on whose behalf claim is made, as often as it may reasonably require. It also has the right to make an autopsy when not forbidden by law.

E. PHYSICIAN-PATIENT RELATIONSHIP

Any person covered under this Plan will have free choice of any Physician practicing legally. The Plan Administrator and its agents will in no way disturb the Physician-patient relationship.

F. BASIS ON WHICH PAYMENTS ARE BEING MADE FROM THE PLAN

The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Plan Administrator and the amount to be contributed (if any) by each covered Participant. Payments from the Plan shall be made first from any such Participant contributions. The Employer pays Plan benefits and administration expenses directly from general assets.

G. FUNDING POLICY

The Plan operates as an un-funded Plan. Not withstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph entitled "Basis on Which Payments are Being Made from the Plan".

In the event that the Plan Administrator terminates the Plan, then as of the effective date of termination, the Plan Administrator (and covered Employee and dependent Participants) shall have no further obligation to make additional contributions to the Plan. In addition, coverage for allowable claims filed after such Plan termination date shall be limited to those remaining assets of the Plan (if any). If there are not sufficient assets in the Plan to provide the benefits otherwise payable under the Plan, then such benefits shall not be payable under the Plan and neither the Plan Administrator, Administrative Manager, Trustee nor the Plan Supervisor shall be liable for such benefits.

H. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Plan or any provision of similar purpose of any other Plan, the Plan Administrator may, without the consent or notice to any person, release to or obtain from any insurance Company or other organization or individual any information, with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

I. FACILITY OF PAYMENT

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

J. RIGHT OF RECOVERY

Whenever any payment for Covered Expenses has been made by this Plan in an amount which exceeds the Maximum Benefits available under the provisions of this Plan, or when payment has been made in error by the Plan for non-covered expenses, the Plan will have the right to recover such excess or erroneous payment from one or more of the following, as the Plan Administrator shall determine: Any persons to or for or with respect to whom such payment was made, any insurance companies, or any other organizations. As an alternative, the Plan reserves the right to deduct from any pending claim for payment any amounts the Covered Person owes the Plan.

K. MEDIUM OF PAYMENT

All payments made by or to this Plan in connection with the benefits of Covered Persons shall be made in lawful money of the United States, which, at the time of payment, is legal tender for public and private debts.

VI. ELIGIBILITY

A. ELIGIBILITY REQUIREMENTS

Individuals who meet the following requirements are eligible for coverage under the Plan:

1. Full time Employees who have completed the Waiting Period and who are regularly scheduled to work at least 30 hours per week (herein called Employees within the eligible classes); and
2. Dependents of eligible Employees provided such dependents meet the requirements listed under the Dependent Eligibility section of this Plan.

Benefits will not be paid for retired, part time, temporary, seasonal, independent contracted, or leased (even if determined to be common-law employees) Employees and their dependents.

Each Employee must complete and sign an enrollment form that the Plan Administrator has approved within 30 days of their Initial Eligibility Date.

No coverage is provided for Late Enrollees (individuals who do not enroll within 30 days of their Initial Eligibility Date). A Special Enrollee, as described in section E, shall not be considered a Late Enrollee.

B. EFFECTIVE DATE - EMPLOYEES

For all eligible Employees, coverage may begin on the Initial Eligibility Date, which is the date of hire.

If an Employee is not actively at work on the scheduled effective date except for health related causes and the effective date is a regularly scheduled workday, neither Employee nor dependent coverage begins until the day the Employee returns to active, full-time employment.

If the scheduled effective date falls on a non-work or vacation day, coverage begins on the scheduled effective date if the Employee was actively at work on the last preceding regularly scheduled work day or, if absent for work; such absence was due to health related causes. Otherwise, neither Employee nor dependent coverage begins until the day the Employee returns to active, full-time employment.

C. DEPENDENT ELIGIBILITY

1. Eligible Dependents of an Employee are:

    a. A legal Spouse of the opposite sex. Such Spouse must meet all requirements of a valid marriage contract in the state of residence but will not include a common law Spouse; and
    b. Children who are under twenty-six (26) years of age. “Children” include:
        - an Employee’s natural children.
        - step children, legally adopted children, and foster children placed with the Employee by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction, and any other legal children of the Employee and/or Spouse.
        - children who have been placed with the employee for the purpose of adoption, and a child for whom the Employee or covered spouse is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) which is determined solely by the Plan Administrator and in

accordance with its written procedures (which are incorporated herein by reference).

c. If an unmarried child is (on the date such child's coverage would otherwise terminate due to age) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and such incapacity commenced prior to the date such child's coverage would otherwise terminate, and such child is chiefly dependent upon the Employee for support and maintenance, the Plan will, upon payment of the applicable premium, continue coverage for such unmarried child so long as such Employee's coverage remains in force and such incapacity continues; provided proof of such incapacity is submitted to the Plan within 30 days of the date dependent coverage would otherwise have terminated.

2. If both parents or stepparents are covered under the Plan as Employees, either, but not both, may elect to cover children eligible as described above. Children are never eligible to be covered by two (or more) entities under the same plan. Eligible Dependents will not include any person who is covered as an Employee.

3. Benefits payable on behalf of a Dependent previously covered under the Plan as an Employee for medical, dental, and vision expenses incurred during a period which began while the Dependent was covered as an Employee shall not exceed the benefits that would have been payable during such period had the Dependent remained covered as an Employee. This provision also applies to Employees previously covered under the Plan as a Dependent.

D. EFFECTIVE DATE – DEPENDENTS

Coverage for eligible dependents that are enrolled concurrently with the Employee will begin on the Employee's effective date. Coverage for eligible dependents that are acquired after the Employee's effective date will begin as follows:

1. Newborn or newly adopted children will be covered from the moment of birth or placement for adoption for Injury or Illness, including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled within thirty (30) days of the child's date of birth or placement for adoption. This provision shall not apply to or in any way affect the normal maternity provisions applicable to the mother.

2. A Spouse will be considered an eligible Dependent from the date of marriage, provided the Spouse is properly enrolled within thirty (30) days of the date of marriage.

3. If a Dependent is acquired or otherwise becomes eligible other than at the time of his birth due to a court order, decree, or marriage, that Dependent will be considered an eligible Dependent from date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled within thirty (30) days.

4. A child may become eligible as set forth in a Qualified Medical Child Support Order (QMCSO). The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a Qualified Medical Child Support Order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order. Such children may remain covered for the duration of the QMCSO or until proof is provided of comparable coverage, subject to the provisions of the Plan.

E. SPECIAL ENROLLEES

1. **Employees -** An Employee who is eligible, but not enrolled in this Plan, may enroll if the request for coverage is received within 30 days of the special enrollment event, and if:
   a) An eligible Employee who experiences a family status change through marriage, birth, adoption, placement for adoption, or receives a judgment, decree, or order requiring coverage; or
   b) There is a total loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, strike or lock out, commencement of leave of absence, change in residence for a region specific plan (including a HMO), new requirement to pay premiums on a previously 100% Employer paid plan, or exhaustion of COBRA coverage. "Loss of Coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim). If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and
   c) A HIPAA special enrollment right is available when an Employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility for that coverage. An Employee must be given a period of at least 60 days after the date of termination of the coverage to request special enrollment; and
   d) The Employee requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

2. **Dependents -** A dependent who is eligible, but not enrolled in this Plan, may enroll if the request for coverage is received within 30 days of the special enrollment event, and if:
   a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
   b) A person becomes a dependent of the Employee through marriage, birth, death, adoption, placement for adoption, or receives a judgment, decree, or order requiring coverage; or
   c) There is a total loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, strike or lock out, commencement of leave of absence, change in residence for a region specific plan (including a HMO), new requirement to pay premiums on a previously 100% Employer paid plan, or exhaustion of COBRA coverage. "Loss of Coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim). If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and
   d) A HIPAA special enrollment right is available when an Employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility for that coverage. An Employee must be given a period of at least 60 days after the date of termination of the coverage to request special enrollment.

   Then the dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as

a dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The coverage of the dependent enrolled in the Special Enrollment period will be effective:

a) in the case of marriage, the date of marriage;
b) in the case of a dependent's birth, as of the date of birth; or
c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
d) in the case of loss of coverage, the date of such loss.

3. **No coverage is provided for Late Enrollees.** If application for coverage is not made within 30 days of the Initial Eligibility Date, the individual shall not be eligible to enroll in the Plan except as a Special Enrollee described above, or during an open enrollment period.

F. OPEN ENROLLMENT

The Open-Enrollment Period shall be November 1 through November 30 with coverage effective January 1, so long as the Employee is actively at work as of that date. If the Employee is not actively at work, coverage will begin the first day the Employee returns to active employment. Once an Employee selects a plan during the open enrollment period a Participant may not change plans until the next open enrollment period. A Participant may only make changes such as adding or terminating dependent(s) during the plan year if there is a change in family status (including marriage, divorce, death of a Spouse or child, birth or adoption of a child, termination or commencement of employment, or other such events as the Plan Administrator determines will permit a change or revocation in accordance with applicable laws).

G. REINSTATEMENT/REHIRE

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave the Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires. No Waiting Period requirement will be applied.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service.

H. EMPLOYEES ON MILITARY LEAVE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be the lesser of:
   a) The 24 month period beginning on the date on which the person's absence begins; or

b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

2. A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

I. EMPLOYEE CONTRIBUTIONS

The Employee may be required to contribute to the cost of single and/or family coverage.

VII. TERMINATION OF BENEFITS

A. TERMINATION FOR EMPLOYEE

Your coverage will terminate on the earliest of the following dates:

1. The date the Plan is terminated;
2. The date the Plan is amended to terminate the coverage of a class of Employees of which you are a member;
3. With respect to any coverage for which you cease to be a member of the class or classes of Employees eligible for such coverage, the date cessation of such membership;
4. The day on which you cease to be regularly scheduled to work at least 30 hours per week - this includes death or termination of active employment.
5. The date ending the period for which your last contribution is made, if you fail to make any required contribution or COBRA premium towards the cost of coverage when due.
6. December 31 of the Plan year in which the Employee elects to terminate coverage during an annual enrollment period designated by the Employer.
7. The date on which the Employee elects to terminate coverage, provided such election is made within 30 days of the date the Employee experiences a qualifying Family Status Change.
8. The date you enter the armed forces or active duty except for continued coverage as provided in 38 USC Sec. 4317, which applies to an Employee who is called into uniformed service as a result of being an armed forces veteran, a member of the National Guard, or military reservist.

B. TERMINATION FOR DEPENDENT

Your coverage with respect to dependents will terminate on the earliest of the following dates:

1. The date ending the period for which your last contribution is made, if you fail to make any required contribution or COBRA premium towards the cost of coverage for your dependents when due; or
2. The date the Employee's coverage is terminated for any reason including death; or
3. The date a dependent ceases to be eligible as a dependent except as provided below; or
4. The date a covered Employee elects to terminate Dependent coverage.

Coverage providing benefits for medical care expenses may be continued for a Dependent who is mentally or physically incapable of earning a living and who is dependent upon you for support and maintenance provided you furnish evidence of the Dependent's incapacity within 30 days after the Dependent reaches the limiting age.

Any coverage continued for such a Dependent child will terminate under any of the conditions described above, or, in any event, when the Dependent ceases to be incapacitated, or at the end of the 30 day period after any requested proof of continued incapacity is not furnished.

C. MISREPRESENTATIONS

Benefits may be denied or coverage terminated if:

1. It is found that a Covered Person's application or intentional failure to disclose facts contains intentional misrepresentations designed to cause the Plan to issue or maintain the coverage when it would not have ordinarily done so; or,
2. If any claim submitted by the Covered Person contains intentional misrepresentations

designed to cause the Plan to pay benefits in excess of any benefits which would have been otherwise provided.

In the event coverage is terminated due to either of the above, the date of termination will be the Covered Person's original effective date or the date of the claim submission, respectively. The Plan will provide 30 days advanced written notice before rescission of coverage.

D. RESCISSION OF COVERAGE

Notwithstanding anything to the contrary in the Plan, in the event an enrollee's coverage should have been terminated retroactively because the enrollee became ineligible, the enrollee shall automatically be responsible for the full cost of premiums attributable to such coverage from the date of ineligibility. The premium value shall equal the COBRA premium, and shall be due on the first of each month, commencing with the month following the date of ineligibility. If the enrollee was required to provide notice to the Plan Administrator, within 60 days of the event under COBRA, the enrollee's coverage shall be retroactively terminated for failure to pay premiums. If required by COBRA an enrollee shall be provided with a COBRA election notice which allows the person to elect to continue coverage retroactive to the date of ineligibility, provided that coverage will retroactively terminate if the individual does not timely pay COBRA premiums.

VIII. SPECIAL PROVISIONS

A. INFORMATION OF INTEREST

1. GENERAL INFORMATION

Participants and beneficiaries should be furnished with certain information about the operation of the Plan. This information follows:

a) **Name of This Plan -** The name of this Plan is City of Murray Health Care Plan.

b) **Type of Plan -** This is a self-funded group health Plan maintained by the Employer providing comprehensive medical expense benefits, prescriptions drug card benefits, vision benefits, and dental benefits. For specific coverage see the Schedule of Benefits outlined in this booklet.

c) **Fiscal Year:** The accounting records of this Plan are kept on the basis of a fiscal year which ends on June 30 each year.

d) **Name and Address of Plan Administrator and Named Fiduciary.** The Plan Administrator and Named Fiduciary is City of Murray. Any communication with the Plan Administrator should be addressed to the Plan Office at:

City of Murray Health Care Plan
608 Main Street
Suite A
Murray, KY 42071

e) **Plan Administrator Authority and Discretion:** The Plan Administrator shall have the authority to administer the Plan by its provisions and to decide all questions arising thereunder. This authority specifically includes, but is not limited to: (1) the discretion to interpret all provisions of the Plan, including eligibility provisions; (2) the discretion to apply all provisions of the Plan, including eligibility provisions; (3) the discretion to make factual determinations in respect to whether a claim is covered by the Plan; (4) the discretion to determine the type of benefits payable for a claim that has been determined to be payable; (5) the discretion to make all decisions regarding management of Plan assets.

All determinations made by the Plan Administrator are final, conclusive and binding.

2. TYPE OF ADMINISTRATION

The Company is legally designated as the Plan Administrator, and has delegated certain ministerial duties to North America Administrators, L.P. The staff, maintained by North America Administrators, L.P. keeps the eligibility records provided by the Employer, processes claims, and performs other routine functions in accordance with Plan decisions.

3. AGENT FOR SERVICE OF LEGAL PROCESS

Every effort will be made by the Plan to resolve any disagreements with Participants promptly and equitably. It is recognized, however, that on a few occasions, some Participants may feel that it is necessary for them to take legal action. The following is the Agent for service of legal process for the Plan: City of Murray, 608 Main Street, Suite A, Murray, KY 42071.

4. PLAN IDENTIFICATION NUMBERS

When filing various reports with the Department of Labor and Internal Revenue Service, certain numbers are used to properly identify City of Murray Health Care Plan including:

Employer Identification Number (EIN), assigned by the Internal Revenue Service 61-6001881

B. CONTINUATION OF COVERAGE

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This provision contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. The Plan Administer has contracted with North America Administrators, L.P., P. O. Box 1984, Nashville, TN 37202, 615-256-3561, to conduct the day-to-day COBRA continuation coverage operations of the Plan (North America Administrators, L.P. is not the Plan Administrator or a fiduciary of the Plan).

1. CONTINUATION OF COVERAGE PROVISION

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." The Employee, Spouse, and dependent children could become qualified beneficiaries if coverage under the Plan is lost due to a qualifying event. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights as any other Participant or beneficiary covered under the Plan.

Employees will become a qualified beneficiary if coverage is lost under the Plan due to either of the following qualifying events:

a) Termination of employment (except for termination due to gross misconduct); or
b) Reduction in hours of employment.

The Spouse of an Employee will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

a) Employee dies;
b) Employee's hours of employment are reduced;
c) Employee's employment ends for any reason other than gross misconduct; or
d) Divorce or legal separation. Also, if the Employee reduces or eliminates Spouse's group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for the Spouse even though coverage was reduced or eliminated before the divorce or legal separation.

A dependent child of an Employee will become a qualified beneficiary if coverage is lost under the Plan due to any of the following qualifying events:

a) Employee dies;
b) Employee's hours of employment are reduced;
c) Employee's employment ends for any reason other than gross misconduct;
d) Employee becomes divorced or legally separated; or
e) Child is no longer eligible for coverage under the Plan as a dependent child.

A child born to, adopted by or placed for adoption with a covered Employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered Employee is a qualified beneficiary, the covered Employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the Employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable

Plan eligibility requirements.

A child of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered Employee's period of employment with the Employer is entitled to the same rights under COBRA as a dependent child of the covered Employee, regardless of whether that child would otherwise be considered a dependent.

If a proceeding in bankruptcy is filed with respect to City of Murray and that bankruptcy results in the Loss of Coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

2. FAMILY MEDICAL LEAVE

If an Employee takes Family Medical Leave (FMLA) and does not return to work at the end of the leave, the Employee (and Employee's Spouse and dependent children, if any) will be entitled to elect COBRA if they were covered under the Plan on the day before the FMLA leave began or became covered during the FMLA leave, or they will lose coverage within 18 months because of the Employee's failure to return to work at the end of the leave. COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave.

3. FEDERAL TRADE ADJUSTMENT ASSISTANCE

Special COBRA rights apply to certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members during a special second election period. This special second election period lasts for 60 days or less. It is the 60 day period beginning on the first day of the month in which an eligible Employee or former Employee becomes eligible for TAA or ATAA, but only if the election is made within 6 months immediately after the individual's group health plan coverage ended. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282.

More information is also available at www.doleta.gov/tradeact/2002act_index.asp.

4. NOTICE REGARDING QUALIFYING EVENTS

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Third Party Administrator has been notified that a qualifying event has occurred. It will be the responsibility of the Employer to notify the Third Party Administrator within 30 days after an Employees' death, termination, or reduction in work hours, (it is the Employee's responsibility to notify the Employer), or for retirees upon commencement of a bankruptcy proceeding in respect to the Employer.

The eligible beneficiary or covered Employee must notify the Plan Administrator (City of Murray, 608 Main Street, Suite A, Murray, KY 42071, 270-753-7278) in writing within 60 days after a Spouse is separated or divorced or a dependent child ceases to be eligible on the basis of attained age or loss of dependent status, or within 60 days in which the qualified beneficiary loses coverage under the terms of the Plan as a result of the qualifying event. Any notice provided must be in writing. Oral notice, including notice by telephone, is not acceptable. If mailed, notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name of the Plan,

the name and address of the Employee covered under the Plan, and the name(s) and address (es) of the qualified beneficiary (ies). Notice must also name the qualifying event and the date it happened and include the applicable copy of the social security determination for disability, divorce decree, or child's birth certificate. Notice of a second qualifying event also must name the event and the date it happened.

5. DURATION OF CONTINUATION

Once the Third Party Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. The beneficiary will have 60 days following the date notice of continuation right is sent by the Plan Administrator, or the date of the qualifying event, whichever is later, to elect COBRA continuation coverage.

When the qualifying event is the death of the Employee, divorce or legal separation, or a cessation of eligibility on the part of a covered dependent as defined under the terms in the Plan, COBRA continuation coverage can last for up to 36 months.

When the qualifying event is termination of employment or reduction in hours, coverage may be continued for up to 18 months. These 18 months may be extended for the Spouse and dependent children to a maximum of 36 months from the date employment was terminated or hours reduced if a second qualifying event (such as a death, divorce, or legal separation) occur during that 18-month period. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. However, the Plan Administrator (City of Murray, 608 Main Street, Suite A, Murray, KY 42071, 270-753-7278) must be notified in writing of the second qualifying event within 60 days of the second qualifying event, or 60 days from the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event.

If an Employee, Spouse, or dependent child who is covered under the Plan is disabled before or during the first 60 days of COBRA, and is subsequently determined to be disabled under the Social Security Act before the end of the 18 month period of COBRA, and you notify the Plan Administrator in writing within 60 days of the date of the determination or within 60 days of the date of the Employee's termination or reduction of hours, or the date on which the qualified beneficiary loses coverage under the terms of the Plan as a result of the covered Employee's termination or reduction in hours, the maximum period of coverage continuation may be extended an additional 11 months (to a maximum COBRA coverage period of 29 months). This extension is available only for qualified beneficiaries who are receiving COBRA coverage due to the qualifying event being the covered Employee's termination of employment or reduction in hours.

Notwithstanding any of the foregoing, in the event an enrollee's coverage should have been rescinded retroactively, but cannot because of the Patient Protection and Affordable Care Act (PPACA), then the period of time following the date coverage should have been terminated shall be considered employer-subsidized COBRA continuation. Upon prospective termination of coverage, an enrollee shall be provided with a COBRA election notice which allows the person to elect to continue coverage at his cost for the remaining COBRA period.

6. COST OF CONTINUED COVERAGE

In the event continuation is elected, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. The qualified beneficiary must make payment of the initial contribution within 45 days of the date of the election.

Those individuals electing continuation of coverage must pay a contribution which will be 102% of cost of the Plan. (For the 11 month extension for a Total Disability, the contribution will be increased to 150% of the cost of the Plan.)

Payment of the required contribution will be due on a monthly basis and must be postmarked by the 30th day of the month for which it is due to be considered timely. **LATE PAYMENTS WILL NOT BE ACCEPTED AND RESULT IN TERMINATION OF COVERAGE.** No notices will be sent and it will be the sole responsibility of the individual to make timely payment of contributions. Payments must be sent to the address indicated on the election notice provided at the time of the qualified event.

7. TERMINATION OF CONTINUED COVERAGE

Continuation coverage will be terminated before the end of the maximum period if:

a) any required premium is not paid in full on time;
b) a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan;
c) a qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage, or;
d) the Employer ceases to provide any group health plan for its Employees; or
e) during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Participant or beneficiary not receiving continuation coverage (such as fraud).

The Plan Administrator must be notified within 30 days of, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or is determined to no longer be disabled.

8. ADDITIONAL INFORMATION

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

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

9. INFORMATION ABOUT HEALTH FSA COBRA COVERAGE

The monthly COBRA premium for coverage under a health FSA maintained by the Employer is 102% of the monthly premium that the Employee was paying via salary reductions before the date of the qualifying event. The health FSA COBRA premium must be paid by check with after-tax dollars. COBRA coverage will consist of the health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule explained in the health FSA summary will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage will terminate at the end of the Flex plan year. Unless otherwise elected, the Spouse and dependents of the person electing COBRA will be covered too. Each beneficiary has separate election rights and could alternatively elect separate COBRA coverage to cover that

beneficiary only, with a separate health FSA annual limit and a separate premium. See the Plan Administrator for more information.

10. HEALTH INSURANCE MARKETPLACE

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Please contact Health & Human Services at 1-800-318-2596, for further information. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

C. FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Regardless of the Employer's established leave of absence policies, this Plan will at all times comply with the regulations of the Family and Medical Leave Act of 1993 as set forth by the Department of Labor.

During a leave, an Employee's participation in the Plan may terminate as a result of non-payment of the Employee contribution required in order to participate in the Plan. Upon the eligible Employee's timely return from leave as specified by the Employer, the Employee's coverage under the Plan (including coverage for eligible dependents if covered under the Plan at the time coverage terminated) will become effective on the date of the eligible Employee's actual return to work, provided written application to elect coverage under the Plan is made within 30 days of the date the Employee returned to work. In such instances the waiting period will not apply. However, the Plan will not be required to pay for any charges incurred during the period in which coverage was terminated under the Plan. If coverage under the Plan is elected after the time period specified above, the Employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provision of the Plan.

If an Employee does not return to work from FMLA leave, Coverage under this Plan will terminate unless election is made to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

D. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act ("Newborns' Act") includes important protections for mothers and their newborn children with regard to the length of the Hospital stay following childbirth. The Newborns' Act requires that group health plans that offer maternity coverage pay for at least a 48-hour Hospital stay following childbirth (96-hour stay in the case of Cesarean section).

E. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act (WHCRA) requires all group health plans and health issuers that already offer benefits for a mastectomy, to also provide coverage for the ensuing breast reconstructive surgery. Plans also have to cover surgery on the nonaffected breast to ensure a symmetrical appearance. The WHCRA also mandates

coverage for prostheses and for all other services used to treat physical complications during all stages of a mastectomy, including lymphedemas.

In addition, the WHCRA prohibits group health plans and health insurance issuers from denying renewal or initial enrollment to an individual in order to avoid providing the mandated benefits. Finally, health plans may not use financial incentives (monetary or otherwise) in order to discourage attending health Providers from performing the medical services described in the WHCRA.

The Plan is required to provide Participants with an annual notice about these coverage standards upon enrollment and annually thereafter. Specifically, WHCRA requires that the Plan provide the following benefits coverage:

1. Reconstructive surgery after a mastectomy;
2. Surgery on the nonaffected breast to ensure a symmetrical appearance;
3. Prostheses; and
4. Other physical complications stemming from a mastectomy, including lymphedemas.

In accordance with WHCRA, the Plan provides the Participant with the above coverages. Please note that such coverage is subject to all other provisions of the Plan, including any Deductible Amount and/or coinsurance provisions under the Plan.

F. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA") – PRIVACY RULES EFFECTIVE 04/14/04

This provision permits the Plan Administrator to receive Protected Health Information in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

1. THE FOLLOWING DEFINITIONS APPLY FOR PURPOSES OF THIS PROVISION:

a) **"Health Maintenance Organization"** is defined as it is in 45 C.F.R. 160.103, or any successor thereto.
b) **"Health Insurance Issuer"** is defined as it is in 45 C.F.R. 160.103, or any successor thereof.
c) **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
d) **"Protected Health Information"** is defined as it is in 45 C.F.R. 164.501, or any successor thereto.

2. PLAN ADMINISTRATOR'S CERTIFICATION OF COMPLIANCE

Prior to receiving any Protected Health Information, the Plan Administrator will certify that this provision has been incorporated into the Plan documents and that the Plan Administrator agrees to abide by the provisions herein. Neither the Plan, a Health Care Maintenance Organization, nor a Health Insurance Issuer will disclose Protected Health Information to the Plan Administrator until the Plan Administrator has provided the certification, as required by HIPAA.

3. PERMITTED USES AND DISCLOSURES

The Plan Administrator may use or disclose Protected Health Information to carry out Plan administration functions consistent with the requirements of HIPAA. Any disclosure to and use by the Plan Administrator of Protected Health Information will be subject to and consistent with the provisions herein. The Plan Administrator may use and disclose Protected Health Information to the extent necessary to comply with its obligations under HIPAA.

4. RESPONSIBILITIES AND UNDERTAKINGS

a) The Plan Administrator will not use or further disclose protected Health Information, except as permitted or required by the Plan documents, as amended, or as required by law.
b) The Plan Administrator will ensure that any agent, including any subcontractor to whom it provides Protected Health Information, agree to the same conditions and restrictions that apply to the Plan Administrator.
c) The Plan Administrator will not use or disclose Protected Health Information for employment-related actions or decisions or in connection with any other benefit or Employee benefit plan of the Plan Administrator.
d) The Plan Administrator will report to the Plan any use or disclosure to Protected Health Information that is inconsistent with the uses and disclosures allowed under this provision promptly upon learning of the inconsistent use or disclosure.
e) The Plan Administrator will make Protected Health Information available to the individual who is the subject of the information in accordance with 45 Code of Federal Regulations 164.524.
f) The Plan Administrator will make an individual's Protected Health Information available for amendment, and will incorporate any amendments to the individual's Protected Health Information, in accordance with 45 Code of Federal Regulations 164.526.
g) The Plan Administrator will keep track of disclosures it may make of Protected Health Information so that it can make available the information required for the Group Health Plan to provide an accounting of disclosure in accordance with 45 Code of Federal Regulations 164.528.
h) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Parts 160-64.
i) If feasible, the Plan Administrator will return or destroy all Protected Health Information, in any form, received from the Plan, and the Plan Administrator will not retain copies of the information after the information is no longer needed for the purpose for which the disclosure was made. If returning or destroying the information is not feasible, the Plan Administrator will limit the use or disclosure of the information to those purposes that make the return or destruction infeasible.
j) The Plan Administrator further agrees that if it creates, receives, maintains, or transmits any electronic protected health information, other than enrollment/disenrollment information and summary health information, it will comply with the HIPAA security regulations, effective as of the date set forth in the regulations, on behalf of the covered entity, and it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and it will ensure that any agents, including subcontractors, to whom it provides such electronic protected health information, agree to implement reasonable and appropriate security measures to protect the information. The Plan Administrator will report to the Plan any security incident of which it becomes aware.

5. ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE GROUP HEALTH PLAN.

a) The Plan Administrator shall insure that the adequate separation between the group health plan and the Plan Administrator is established.
b) All Employees, classes of Employees, or other workforce members as designated by the terms of the plan document, who have access to Protected Health Information, have been trained to appropriately handle Protected Health Information in accordance with the HIPAA privacy rules.
c) The Employees, classes of Employees or other workforce members identified in the plan document will have access to Protected Health Information only to perform the Plan's administration functions that the Plan Sponsor provides for the Plan.
d) The Employees, classes of Employees or other workforce members identified in the plan document will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Administrator for any use or disclosure of Protected Health Information that violates the provisions herein. The Plan Administrator will promptly report any violation to the Plan, as required by this provision. The Plan Administrator will also cooperate with the Plan to correct the violation, to impose appropriate disciplinary action or sanctions on each Employee or other workforce member causing the violation, and to mitigate any deleterious effect of the violation on the individual whose privacy rights may have been compromised by the violation.
e) The Plan Administrator will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

IX. DEFINITIONS

To understand the benefits provided for you and your Dependents, it is necessary to know the following terms:

Accidental Bodily Injury or Injury - A bodily injury sustained accidentally and independently of all other causes by an outside traumatic event or due to exposure to the elements that is unforeseen, unexpected, involuntary, and due to violent and external means. The terms "accidental bodily injury" and "injury" do not include injury which arises out of or in the course of any employment or occupation for compensation or profit. Any expense incurred more than 90 days from the date of the accident is considered due to an Illness.

Actively at Work - On a specified day, an Employee is not absent from work. If an Employee is not actively at work on the scheduled effective date except for health related causes and the effective date is a regularly scheduled workday, neither Employee nor dependent coverage begins until the day the Employee returns to active, full-time employment. If the scheduled effective date falls on a non-work or vacation day, coverage begins on the scheduled effective date if the Employee was actively at work on the last preceding regularly scheduled work day or, if absent for work; such absence was due to health related causes. Otherwise, neither Employee nor dependent coverage begins until the day the Employee returns to active, full-time employment.

Ancillary Charges. Charges for Hospital services that are exclusive of such routine services as room and board and nursing. Examples of Ancillary Charges include X-rays and laboratory charges.

Annual - Calendar Year (January 1 - December 31).

Average Semi Private Rate – The most common rate for a semi private room. If the Hospital is an all private room Hospital, the most common semi private rate will be deemed to be the prevailing private room rate.

Benefits Payable - When you incur Covered Expenses for yourself or on behalf of a Dependent for care of Injury or Illness, while covered under the Plan, you will become entitled to comprehensive medical benefits, subject to the Deductible Amount and any benefit limitations as provided in the Schedule of Benefits.

Certificate of Creditable Coverage – The certification of coverage that must be provided to the Covered Person when coverage under a Plan ceases. The certification must be provided automatically within a reasonable time period after coverage ceases and in the twenty-four (24) month period after coverage ceases, upon request.

Chemical Dependency - A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Child - Any individual up to 26 years of age who otherwise meets the definition of dependent under the Plan.

Clean Claim - A claim devoid of any omissions of pertinent information, including coordination of benefits issues and any liability issues.

COBRA - The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

COBRA Continuee - A person who is receiving continuation of coverage (within the meaning of Section 4980B of the Code) under a group health care Plan maintained by the Employer. A person shall cease to be a COBRA Continuee on the date that the "maximum required period" (as defined in Section 4980B of the Code) ends for the "qualifying event" (as defined in Section 4980B of the Code) giving rise to his continuation coverage or if earlier, when COBRA coverage terminates hereunder.

Code - The Internal Revenue Code of 1986, as amended from time to time.

Company – the Employer maintaining this Plan of benefits.

Covered Person - An eligible Employee or eligible Dependent who is covered under this Plan.

Creditable Coverage - This term is defined in ERISA Section 701 (c). Under this provision, Creditable Coverage generally includes periods of coverage under an individual or group health Plan (including Medicare, Medicaid, governmental and church Plans) that are not followed by a 63 day break in coverage. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits. Waiting Periods and HMO affiliation periods are not considered a break in coverage.

Custodial Care - Services, including Room and Board, or supplies provided to a person:

- Who is not receiving medical treatment for rehabilitation from an injury or Illness; or
- For the purpose of assisting the person in the activities of daily living; and
- When such services or supplies do not require the continuous attention of trained medical personnel.

Custodial Care includes but is not limited to: administration of medicines, dressings or therapies which can be self-administered; routine monitoring of vital signs; help in walking, getting in and out of bed, and bathing, dressing and eating.

Deductible - The amount of the Deductible as it applies to Covered Expenses is shown in the Schedule of Benefits. The Deductible Amount applies separately to each member of your family once during each calendar year (except as provided under "Family Limit" below) even though expenses may be incurred for several Illnesses or accidents during the year.

a) **Family Limit** - Normally, the Deductible Amount applies separately to each member of the family. However, after you have satisfied the Family limit indicated in the Schedule of Benefits, Covered Expenses incurred by you or on behalf of any other members of your family during the remainder of the calendar year will not be subject to Deductible Amounts.

Durable Medical Equipment - Equipment which (a) can withstand repeated use, (b) can only be used to serve the medical purpose for which it is prescribed, (c) generally is not useful to a person in the absence of an Illness or accidental bodily injury, (d) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be DURABLE MEDICAL EQUIPMENT. Such equipment will not be considered a covered service simply because its use has an incidental health benefit.

Emergency - The term "Emergency" means the following:

1. **Accident:** A sudden and unforeseen event which includes all of the following:
   a) causes injury to the physical structure of the body;
   b) results from an external agent or trauma;
   c) is definite as to time and place; and
   d) happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.
2. **Emergency Illness:** A medical condition that is not accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in any of the following:
   a) permanently placing the participant's health in jeopardy;
   b) causing other serious medical consequences;
   c) causing serious impairment of bodily function; or
   d) causing serious and permanent dysfunction of any bodily organ or part.

Employee – One who provides services for wages or salary and receives a W-2 from the Employer.

Employer – One who engages the services of others for wages or salary.

Enrollment Date - The first day of coverage under this Plan (see Eligibility Requirements) or, if earlier, the beginning of any applicable Waiting Period hereunder.

Experimental or Investigational - Any treatment, equipment, new technology, drug, procedure, or supply which:

a) Is not accepted as standard medical treatment for the Illness, disease or injury being treated by Physicians practicing the suitable medical specialty; or
b) Is the subject of scientific or medical research or study to determine the item's effectiveness and safety; or
c) Is being used or studied in proposed or ongoing clinical research or clinical trials as evidenced by an Informed Consent or treating facility's protocol; or are part of a proposed or ongoing Phase I, II, or III clinical trial; or are the subject of proposed or ongoing research or studies to determine their dosage, safety, toxicity, efficacy, or their efficacy as compared to other means of treatment or diagnosis; or
d) Has not been granted, at the time services were rendered, any final approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency, and The Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
e) Has not received the approval or endorsement of the American Medical Association (AMA) for the specific injury or illness being treated; or
f) Has not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific injury or illness to be treated; or
g) Is performed subject to the Covered Person's informed consent under treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

In determining whether a treatment, equipment, technology, drug, procedure, or supply is Experimental, the view of the state or national medical communities shall be considered as well as whether:

a) Scientific evidence permits conclusions concerning the effect of health outcome;
b) The net health outcome for the patient is improved, as much or more than established alternatives; and
c) Improvement in the patient's condition would be attainable through the use of more conventional or widely recognized treatment alternatives.

Treatment may be considered Experimental within this definition, even if a Physician has

previously prescribed, performed, ordered, recommended, or approved such treatment. Charges for Experimental or Investigational treatment, equipment, new technology, drug, procedure, service, or supply are excluded from coverage.

Formulary: Formulary drugs are a list of prescription drugs that have been selected and approved by the Pharmacy and Therapeutics committee for their safety, quality, and cost effectiveness.

Generic: Medications that have the same active ingredients, and provide the same clinical benefits, as their brand-name counterparts. Generic equivalents become available when a brand-name drug patent expires.

Genetic Information. The term "Genetic Information" means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Hospital - An institution which meets fully every one of the following tests:

a) It provides medical and surgical facilities for the treatment and care of injured or sick persons on an inpatient basis. The requirement of surgical facilities shall not apply to a Hospital specializing in treatment of Mental/Emotional Conditions or Alcohol/Drug Dependency.
b) It is under the supervision of a staff of Physicians;
c) It provides twenty-four hour a day nursing service by registered graduate nurses (R.N.'s);
d) It is duly licensed as a Hospital except that this requirement will not apply in the case of a state tax-supported institution; and
e) It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or custodial or training type institution, or an institution which is supported in whole or in part by a federal government fund.

For the purpose of alcohol or other drug dependency treatment, a Hospital shall mean a facility or institution which provides a program for the treatment of alcohol or other drug dependency pursuant to a written treatment Plan approved and monitored by a Physician. Such a facility must also be:

a) Accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the A.M.A. and A.H.A., or
b) Affiliated with a Hospital, as defined above, under a contractual agreement with an established system for patient referral; or
c) A state agency; or
d) Licensed, certified or approved as an alcohol or other drug dependency treatment program or center by any state agency having legal authority to so license, certify, or approve.

Hospital shall also mean, where appropriate in context, Ambulatory Surgical Center, which means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

Human Growth Hormone. The term "Human Growth Hormone" means an adenohypophyseal hormone that promotes growth and also has direct influence on the metabolism of carbohydrates, fats, and proteins.

Illness - A bodily disorder, disease, physical sickness, mental infirmity, or functional

nervous disorder 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.

Intensive Care Accommodation or Cardiac Care Accommodation- An accommodation which is reserved for critically and seriously ill patients requiring constant audio-visual observation as prescribed by the attending Physician, and which provides Room and Board, nursing care by nurses whose duties are confined to care of patients in the intensive care or cardiac care accommodation, and special equipment or supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Loss of Coverage - Loss as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or exhaustion of COBRA coverage. "Loss of Coverage" does not include loss due to failure to pay premiums on a timely basis, a voluntary election to terminate such coverage, or termination of coverage for cause (such as making a fraudulent claim).

Maximum Benefit - The amount of the Maximum Benefit is shown in the Schedule of Benefits. It applies separately to Covered Expenses incurred by you for yourself and on behalf of each of your Dependents. The Annual Maximum is applicable to all benefits paid for an Employee or dependent under the Plan during the calendar year. No restoration of the Annual Maximum will result from a Loss of Coverage from a leave of absence, lay-off, or termination of employment. If an individual's coverage under this Plan terminates and resumes within a benefit year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and calendar year maximums.

Medicaid – The medical benefits provided by Title XIX of the Social Security Act, as amended.

Medically Necessary or (Medical Necessity) - The criteria we use to determine the Medical Necessity of Comprehensive Medical Expense under this Plan. To be Medically Necessary, Covered Services must:

a) Be rendered in connection with an Injury or Sickness;
b) Be consistent with the diagnosis and treatment of your condition;
c) Be in accordance with the standards of good medical practice;
d) Not be considered Experimental or Investigative; and
e) Not be for your convenience or your Physician's convenience.

To be Medically Necessary, Covered Services 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 facility is appropriate.

In order for us to pay covered Services, the services must be Medically Necessary. Any service failing to meet the Medically Necessary Criteria may be the Covered Person's liability.

Medicare – The medical benefits provided by Title XVIII of the Social Security Act, as amended.

Mental and Emotional Condition - A condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominant features. Mental and Emotional Conditions include mental

disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis, or inducement.

Named Fiduciary - The person who has the authority to control and manage the operation and administration of the Plan.

Non-Formulary: Drugs that have not been selected and approved by the Pharmacy and Therapeutics committee for their safety, quality, and cost effectiveness.

Out-of-Pocket Maximum – Out-of-Pocket is that portion of Covered Expenses for which the Covered Person is responsible after Plan benefits have been paid. Covered Expenses are payable at the Benefits (percentages) Payable each calendar year until the Individual (or Family) Out-of-Pocket maximum shown in the Schedule of Benefits is reached. Then, Covered Expenses incurred by a Covered Person (or Family) will be payable at 100% for the rest of the calendar year. The Out-of-Pocket Maximums are not combined. Amounts which are applied toward satisfaction of the PPO Out-of-Pocket Maximum will not be applied toward the Out-of-Network Out-of-Pocket Maximum.

Exceptions:

a) The following expenses will not be applied toward the satisfaction of the Out-of-Pocket Maximums, nor will benefits for these expenses ever be payable at 100%: Any Penalties; Prescription benefits, Out of Network Transplant services; Non-covered services; Any covered expense for which benefits were initially paid at 100%.
b) When there is other secondary coverage for the same Illness or injury for which benefits are payable, the Plan will continue to pay at the applicable co-insurance percentage.

Participant - any Employee or dependent meeting the eligibility requirement and who is covered under this Plan.

Physician or Surgeon - Any professional practitioner who holds a lawful license authorizing the person to prescribe and administer drugs or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Dental Medicine (D.M.D.), a Doctor of Optometry (O.D.), a Doctor of Ophthalmology (O.D), a Doctor of Podiatric Medicine (D.P.M.), a Psychiatrist, or a Doctor of Osteopathy (D.O.).

Plan Administrator - The person responsible for the functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Preferred Provider Organization (PPO) - This Preferred Provider Option is a health care benefit program designed to give the Covered Person a financial incentive to use a designated group of Hospitals and Physicians. The choice of Preferred Providers is based on a range of services, geographic locations, cost-effectiveness, and quality health care.

As a Covered Person under the Preferred Provider Option, the Covered Person will have access to the PPO website or a direct telephone number for a directory of participating Hospitals and Physicians. Under this option, the Covered Person will continue to have complete freedom of choice of Hospitals and Physicians. However, the Benefit Percentage Payable may be greater if the services of a Preferred Provider are used.

a) **Provider** - any health care facility (for example, a Hospital) or person (for example, a Physician) duly licensed to render covered medical care or services.
b) **Preferred Provider -** a Provider who has entered into an agreement with the

Preferred Provider Organization, to provide services to individuals enrolled as members of the organization.

c) **Non-Preferred Provider -** a Provider that does not meet the definition of Preferred Provider.

If the Covered Person receives treatment or services as a result of an Emergency, benefits will be paid at the PPO Benefits percentage, whether or not a Preferred Provider performed the services. If services are not offered by a Preferred Provider or if a Covered Person lives or is traveling outside of the geographical area (more than 50 miles) of the Preferred Provider Organization (PPO), benefits will be paid at the PPO Benefits percentage. However, in both instances, the individual may be responsible for charges in excess of the Reasonable and Customary Amount.

Primary Care Physician – A family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician, obstetrician/gynecologist, or chiropractor. Generally, these Physicians provide a broad range of services.

Proof of Loss: Proof of Loss constitutes a claim submitted by the Participant which includes: patient name, member name, Provider of services, place of service, date(s) of service, diagnosis, description of services rendered, and extent of the loss. A claim is not considered received if any of this information is omitted.

Proper Enrollment: means completion and signing of an approved form which is received by the Plan Administrator or Administrative Manager within the specified time period as set forth in the Plan.

Provider - An Individual who is:

- Licensed to perform certain health care services and who is acting within the scope of his license; OR
- In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association; and

Including, but not limited to:

- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (C.R.N.A.)
- Doctor of Chiropractic (D.C.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Family Therapist (L.F.T.)
- Licensed Pharmacist
- Licensed Practical Nurse (L.P.N.)
- Licensed Vocational Nurse (L.V.N.)
- Occupational Therapist (O.T.R.)
- Physical Therapist (P.T. or R.P.T.)
- Physician – (see definition of “Physician or Surgeon”)
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.)
- Psychologist. As used herein, the term Psychologist shall include only a practitioner who is duly licensed or certified in the state where the service is rendered, has a doctorate degree in psychology, and has had at least two (2) years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology.
- Registered Nurse (R.N.)
- Registered Nurse Practitioner
- Regulated Physician's Assistant
- Respiratory Therapist

- Speech Therapist

A “Provider” will also include the following when appropriately licensed and providing services which are covered by the Plan:

- Facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Skilled Nursing Facilities, etc.; and
- Birthing Centers;
- Freestanding Public Health Facilities;
- Dialysis and Outpatient clinics under the direction of a Physician (M.D.);
- Home Health care agencies;
- Hospice;
- Medical Supply/equipment companies;
- Portable x-ray companies;
- Independent laboratories;
- Blood banks;
- Ambulance companies;
- Urgent Care centers.

Qualified Medical Child Support Order (QMCSO) - A judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which satisfies all of the following requirements:

a) The order specifies your name and last known address, and the child's name and last known address;
b) The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
c) The order states the period to which it applies; and
d) The order specifies each Plan that it applies to.

The Qualified Medical Child Support Order may not require the Plan to provide coverage for any type or form of benefit not otherwise provided under the Plan.

Reasonable and Customary Amount - With respect to a service rendered or supply furnished, either:

a) The charge made by the Provider for such service or supply if lowest; or,
b) The charge agreed upon by the Plan Administrator & the Preferred Provider Organization; or,
c) The prevailing charge for the same or comparable service or supply made by most Providers in the same area.

The Plan Administrator has the discretionary authority to determine whether a charge is Reasonable and Customary. Such determination will consider the nature and severity of the condition being treated, any medical complications, and any unusual circumstances that would require more time, skill or expertise.

Room and Board - The Hospital's charge for room and linen service; dietary service including meals, special diets and nourishments; and general nursing service.

Significant Break in Coverage - A period of 63 (or more) days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

Skilled Nursing Facility - is a facility that fully meets all of these tests:

a) It is licensed to provide for persons convalescing from Injury or Sickness, with professional nursing services on an inpatient basis. Physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential

daily living activities must be provided.

b) Its services are provided for compensation from its patients and under the full-time supervision of a Physician or a registered nurse.
c) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
d) It maintains a complete medical record on each patient.
e) It has an effective utilization review Plan
f) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or care of Mental Disorders.
g) It is approved and licensed by Medicare.

Sound Natural Teeth – teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Specialist – A Provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists or chiropractors.

Spouse - An individual of the opposite sex who is legally married to a Participant and who is a resident of the same country in which the Participant resides.

Third Party Administrator (TPA)/Administrative Manager - The person or firm providing services to the Employer in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

Total Disability or Totally Disabled - A condition wherein:

a) The Employee is prevented, solely because of an injury or Illness, from engaging in his regular or customary occupation & is performing no work of any kind for compensation or profit; or
b) The Dependent is prevented, solely because of an injury or sickness, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

Waiting Period - The period that must pass under this Plan (or for purposes of determining Creditable Coverage the Waiting Period under any other health Plan) before an Employee or Dependent is eligible to enroll in the Plan.

X. HOW TO FILE A CLAIM

A. CLAIM FILING PROCESS

After you are covered under the Plan, the Plan will process your claim and pay the benefits within the scope of the Plan. In this process, you must also assume some responsibility.

To assist in processing your claim, please follow the steps listed below in the order in which they appear.

- Complete a Statement of Claim form and submit the completed form, along with any bill, to the address on your health coverage identification card.
- Detailed itemized bills may be submitted by you or by the healthcare Provider to the address listed on your health coverage identification card.
- All bills must include the following:
  - patient name
  - dates of service
  - itemized charges
  - diagnosis
  - description of service
  - name and address of Provider
- Forward your completed form, with all itemized bills attached to the address indicated on the I.D. Card.

B. FOREIGN CLAIMS

In the event a Covered Person incurs a Covered Expense in a foreign country, the Covered Person shall be responsible for providing the following before any benefits are payable:

- The claim form, name of Provider, and the invoice or any other documentation required to process the claim must be submitted in the English language.
- The charges for services must be converted into dollars.
- A current conversion chart validating the conversion from the foreign country's currency into dollars.

C. PAYMENT AND ASSIGNMENT OF BENEFITS

Benefits which are payable under this Plan shall be paid to you, whether the claim is made on behalf of yourself or one of your dependents, unless you have assigned the benefits. You may not assign benefits which are payable to you under this Plan or any rights you or a beneficiary may have. You may request, however, that payments be made to a Physician, Hospital, dentist, optician, optometrist or any other legally qualified practitioner practicing within the scope of his license.

D. NOTICE AND AFFIRMATIVE PROOF OF LOSS

A written notice of the injury or of the Illness for which you are making claim must be given to the Third Party Administrator within 45 days of the first day of the Illness or injury for which claim is made and all forms, bills and information necessary to pay the claim must be provided within one year and 90 days from the first day of the Illness or injury for which claim is made.

A notice given to the Third Party Administrator at their principal address with sufficient information to identify the Covered Person shall be considered as compliance with this provision. If the individual does not furnish notice and data within the time provided by the Plan, such lack of notice will not jeopardize the claim if it was shown that it was not reasonably possible to furnish such notice when required, but in no event will a claim be

considered if submitted more than one year and 90 days from the date of loss.

E. CORRESPONDENCE FROM THE PLAN OFFICE

From time to time you will be contacted by the Plan Office to provide additional information necessary in order to completely and thoroughly determine the benefits payable on your claims. It is in your best interest to respond to such requests as quickly as possible since failure to do so will only result in additional delay in the handling of your claim and possibly even the denial of benefits.

The Plan Office will contact you directly by mail and specify the nature of the information it needs. A standard form will be used for this purpose, and the appropriate section will be checked and, if need be, written instructions will be stated clearly on the form. **THIS FORM IS NOT A DENIAL OF YOUR CLAIM -** it is simply a request for additional information. In the event of the denial of claim, you will receive a written narrative statement explaining the reason for the denial and the appropriate provisions upon which that decision is based.

Should you be confused as to what information has been requested, please either contact the Plan Office by mail or by telephone.

F. CLAIMS REVIEW AND APPEAL PROCEDURES

The procedures described below will be followed when making a determination on your claim for benefits under the Plan. For purposes of this section, an adverse benefit decision will include a rescission of coverage.

1. REVIEW PROCEDURES

a. Post-service claims

If you file a claim for a benefit that relates to a service that has already been provided and your claim is denied in whole or in part, you will be notified of the denial within a reasonable period of time, but not later than 30 days after receipt of the completed claim. This period may extend up to 15 days if it is determined that the extension is necessary due to matters out of the administrator's control. If an extension is necessary, you will be notified before the end of the original 30-day period of the circumstances requiring the extension and the date by which a decision is expected. If such an extension is necessary because you did not submit all the information necessary to decide the claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. If you deliver the information within the time specified, the 15-day extension period will begin after you provide the information. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading "Manner and Content of Notice".

b. Pre-service claims

You must submit a claim to the Plan that includes your name, the specific medical condition or symptom for which you are seeking medical attention and the specific treatment, service, or product for which you are seeking approval. You will be notified of the approval or denial of your claim within a reasonable period of time appropriate to the "medical exigencies", but not later than 15 days of receipt of your claim. If it is determined that you have not followed the proper procedures for filing a claim for benefits described above, or that more information is needed before processing your request, you will be notified within five days. You may be asked to explain or describe the "medical

exigencies" in existence that could affect the timing of the decision.

If special circumstances arise beyond the administrator's control, the period within which to render a decision may be extended by an additional 15 days. If an extension is necessary, you will be notified prior to expiration of the initial 15 day period of the circumstances requiring the extension of time and the date by which a decision is expected. If an extension is necessary because you have not submitted all the information necessary to decide your claim, the notice of extension will specifically describe the additional information required. You will have at least 45 days to provide the requested information. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading the "Manner and Content of Notice".

c. Urgent Care

A claim is an "urgent care claim" if processing the claim within the time frame described above could seriously jeopardize your life, health, or ability to regain maximum function, or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment requested in your claim. The following procedures will apply to any urgent care claim:

i. You will be notified of the determination as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your claim is received. You may be asked to explain the medical exigencies relating to your claim.
ii. You may be notified orally if it is determined that your claim is denied, as long as you are given written notification within three days after the oral notification.
iii. If you do not provide sufficient information to determine whether or to what extent the benefits you seek are covered or payable under the Plan, you will be notified within 24 hours of the specific additional information that you must submit.
iv. If you are notified that you need to provide additional information, you will have at least 48 hours in which to provide the additional information.
v. If you have been asked to provide additional information, you will be notified of the decision no later than 48 hours after receipt of the requested information, or, if you do not provide the requested information, you will be notified 48 hours after the end of the period of time that you were given to provide the information.
vi. The notice of any adverse decision on your claim will meet requirements described below under the heading "Manner and Content of Notice". Any adverse benefit determination will describe the expedited review process applicable to urgent care claims.

d. Concurrent Care Decisions

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the following will apply:

i. If the Plan reduces or terminates the Plan or course of treatment (other than by Plan amendment) before the end of the period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of the Plan's decision before it becomes effective.
ii. If you make a request to the Plan to extend a particular course of treatment beyond the already approved time or number, and the failure to extend the time period or course of treatment could seriously jeopardize your life, health, or the regaining of maximum function, or, in the opinion of a Physician with knowledge of your medical condition, failure to extend the time period or course of treatment would subject you to severe pain that cannot otherwise be adequately managed, you will be notified of the decision within 24 hours of receipt of your request, as long as you make your

request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

iii. The notice of any adverse benefit determination will meet the requirements described below under the heading “Manner and Content of Notice”.

2. APPEAL

a. Post-service claims

If your claim is denied, you have 180 days from the receipt of the decision to appeal to the Plan Administrator for a review of the denial. Please send your request for a review to:

City of Murray
c/o North America Administrators, L.P.
P.O. Box 25207
Nashville, Tennessee 37202

The Plan Administrator’s decision on appeal will be given to you in writing within 60 days after receipt of your written request for review. Any notice you receive regarding an adverse decision on your claim will meet the requirements described below under the heading “Manner and Content of Notice”. The following will apply to your right of appeal:

i. You may submit written comments, testimony, documents, records and other information in support of your appeal.
ii. You will have access to copies of all relevant documents, records, and other information, as described by applicable U.S. Department of Labor regulations.
iii. The review on appeal will take into account all comments, documents, records, and other information relating to the claim, whether or not presented or available at the initial determination.
iv. The initial determination will not be afforded any deference in the appeal process. The Plan will also avoid conflicts of interest and ensure that the claim and appeals decisions are decided in an impartial and independent manner.
v. A person different from the person who made the initial determination and who is not the original decision maker’s subordinate will conduct the review.
vi. If the decision is made, in whole or in part, on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan Administrator shall consult with a health care professional with appropriate training and experience. The health care professional will not be the individual who was consulted during the initial determination, or that person’s subordinate.
vii. You will be provided with the name of any medical or vocational expert who advised the Plan with regard to your claim.
viii. Sufficiently prior to the decision, you will also be provided any new or additional evidence and/or rationale considered, relied upon, or generated in connection with the claim. You will be provided a reasonable period to review and respond to such new evidence or rationale.

b. Urgent Care

If your claim was processed as an “urgent care” claim and the claim was denied, you may make a request for an expedited review of the determination orally or in writing. All necessary information regarding the review may be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method. You will be notified of the determination by any of the methods mentioned above as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your request for review is received. You may be asked to explain the medical exigencies that

apply to your request for review. The notice of any adverse determination will meet the requirements described under the heading “Manner and Content of Notice on Appeal”.

c. Pre-service claims

If you appeal the determination with respect to a pre-service claim that was denied, you will be notified of the determination within a reasonable period of time appropriate to the medical circumstances, but in no case later than 30 days. The notice of any adverse determination will meet the requirements described below under the heading “Manner and Content of Notice on Appeal”.

d. Manner and Content of Notice on Appeal

A notice that your claim or request on appeal is denied will be given in writing or electronically and will:

i. Set forth the date of service, provider and claim amount, and describe that the diagnosis code, denial code and treatment code (and their meanings) are available upon the Participant’s request.
ii. State the specific reason or reasons for the determination.
iii. Reference the specific Plan provisions upon which the determination is based.
iv. State that you are entitled access, free of charges, upon request, to all documents records and other information relevant to your claim.
v. Describe your right to bring civil suit under federal law.
vi. Disclose any internal rule, standard, guideline, protocol or similar criterion that was relied upon in making the adverse determination (or a statement that such information will be provided free of charge upon request).
vii. Explain the scientific or clinical judgment for a benefit determination which was based upon a medical necessity or experimental treatment, or other similar exclusion or limit by applying the terms of the Plan to your circumstances (or state that this explanation will be provided free of charge upon request).
viii. State that you or your Plan may have other voluntary alternative dispute resolution options, such as mediation, or provide information about any applicable state consumer assistance program or ombudsman. 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.
ix. If the decision is a final internal adverse benefit determination, describe the availability any additional internal appeal or external review and how to initiate an appeal or external review.

In addition, for notices of final internal adverse benefit determination:

Federal law requires that group health care plans provide a participant the right to request an external review after receiving a notice of final internal adverse benefit determination. This section describes the external review standards implemented by this plan. Upon completion of these procedures, either the claimant or the Plan may request judicial review of the final decision of the claim. Any action brought by, or on behalf of, a claimant for plan benefits must be filed not later than 24 months after completion of the Plan’s internal claims procedure (and external review, if applicable).

e. Right for External Review

A participant shall have the right to request an external review after receiving a final internal adverse benefit determination. For purposes of this section, an adverse benefit determination does not include the denial, reduction, termination or failure to provide payment for a benefit based upon the determination that the participant failed to meet the requirements for eligibility under the terms of this plan.

f. Deadline to Request

The participant must request an external review within four months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination. If the last filing date to request an external review would fall on a Saturday, Sunday or a federal holiday, the last filing date is extended to the next date that is not Saturday, Sunday or a federal holiday.

g. Preliminary Review

Within five business days following the receipt of external review request, the plan administrator, or its delegee, will complete a preliminary review of the external review request to determine whether:

a) The participant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
b) The final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan;
c) The claimant has exhausted the plan's internal review process (unless the claimant was not required to exhaust); and
d) That the claimant has provided all information and forms required to process an external review.

Within one business day after completion of the preliminary review, the plan administrator will issue a written notice to the claimant. If the request is complete, but not eligible for external review, such notice will include the reasons for ineligibility. If the request is not complete, such notification will describe the information or materials needed to make the request complete. The plan will allow the participant to perfect the request for external review within the four-month filing period or 48 hours after receipt of the notice, whichever is later.

h. Referral to Independent Review Organization

The plan will retain at least three independent review organizations ("IRO") for assignment. The plan will assign each IRO a number and will rotate claim assignments among them in sequential order.

The IRO will timely notify the claimant or participant in writing of the eligibility and acceptance for external review. The notice will include a statement that the participant may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, consider additional information submitted after 10 business days.

Within five business days after the assignment to the IRO, the plan will provide to the assigned IRO the documents and information considered in making the adverse benefit determination a final and internal adverse benefit determination. Upon receipt of any information submitted by the claimant, the IRO will, within one business day, forward the information to the plan. The plan may reconsider its adverse benefit determination, but is subject to final review, provided that such reconsideration does not delay the external review process. The IRO will review all information and documents timely received. The IRO will provide written notice of the final external review within 45 days after the IRO receives the request for external review.

i. Expedited External Reviews

Expedited external reviews are available in the event an adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain the maximum function, and the claimant has filed his/her request for an expedited internal appeal. Expedited external reviews are also available where the Plan has made a final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of 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 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 has received emergency services, but has not been discharged, then the claimant may request an expedited external review.

Immediately upon receipt of the request for an expedited external review, the plan will determine whether the request meets the reviewability requirements. The plan will also immediately send a notice that informs the participant whether the request for external review is appropriate.

Upon determination that a request is eligible for expedited external review, the plan will assign an IRO in accordance with the rules above. The plan will provide all necessary documents to the assigned IRO, either electronically, by telephone or facsimile, or other expeditious method.

The IRO will provide notice of a final external review as expeditiously as the claimant's medical conditions or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited review. If the notice is not in writing, the IRO will provide written confirmation to the claimant and the plan within 48 hours after the date of providing the notice.