NOTICE

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Corey Jannett at (409) 770-5345. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
# TABLE OF CONTENTS

ADOPTION OF THE PLAN DOCUMENT ................................................................. 1

ADMINISTRATIVE INFORMATION .................................................................. 2

SCHEDULE OF MEDICAL BENEFITS - BASE ................................................. 3

SCHEDULE OF MEDICAL BENEFITS – BUY-UP ........................................... 5

DIALYSIS CARVE-OUT BENEFIT ................................................................... 7

SCHEDULE OF MEDICAL BENEFITS – MEDICARE SUPPLEMENT ............... 8

GYM MEMBERSHIP REIMBURSEMENT PROGRAM ........................................ 10

ACCUMULATOR PROVISIONS ....................................................................... 11

PRESCRIPTION DRUG CARD PROGRAM .................................................... 13

UTILIZATION MANAGEMENT PROGRAM ................................................... 14

MEDICAL CARE COVERAGES .................................................................... 17

ELIGIBLE MEDICAL EXPENSES ................................................................. 17

MEDICAL LIMITATIONS AND EXCLUSIONS ............................................. 27

GENERAL HEALTH CARE COVERAGE EXCLUSIONS .............................. 30

COORDINATION OF BENEFITS ................................................................... 33

SUBROGATION AND REIMBURSEMENT ..................................................... 37

ELIGIBILITY AND EFFECTIVE DATES ......................................................... 40

TERMINATION OF COVERAGE .................................................................... 47

EXTENSION OF COVERAGE ........................................................................ 48

CONTINUATION OF COVERAGE OPTION (COBRA) ................................... 50

CONTINUATION OF COVERAGE AS A RETIREE ....................................... 53

CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE ......................... 54

DEFINITIONS ................................................................................................. 61

GENERAL PLAN INFORMATION .................................................................... 72

HIPAA PRIVACY RULE AND SECURITY STANDARDS ............................... 77
ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document and Summary Plan Description (the "Plan Document") as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document is a restatement of any prior plan document, with benefit changes, and is effective on January 1, 2017.

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

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

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed, effective as of January 1, 2017.

GALVESTON COUNTY, TEXAS

By: ________________________________

Title: ________________________________

Date: ________________________________
ADMINISTRATIVE INFORMATION

Name of Plan:                      Galveston County Health Protection Plan
                                   Base and Buy-Up Health Plans

Plan Sponsor:                     Galveston County
Address:                          722 Moody Avenue, 3rd Floor
                                   Galveston, Texas 77550

Business Phone Number:            (409) 770-5418

Plan Sponsor ID Number (EIN):     74-6000908

Group Number:                     002-213

Plan Year:                        January 1 – December 31

Plan Benefits:                    Major Medical
                                   Prescription Drug Card

Plan Administrator (Named Fiduciary): Director/Chief of Human Resources
                                   Galveston County
Address:                          722 Moody Avenue, 3rd Floor
                                   Galveston, TX 77550

Business Phone Number:            (409) 770-5418

Designated Legal Agent:           Director of County Legal Department
                                   Galveston County
Address:                          722 Moody Avenue, 5th Floor
                                   Galveston, TX 77550

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

Participating Employers:          Galveston County


Street Address:                   9401 Amberglen Blvd. Building I, Suite 100
                                   Austin, Texas 78729

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

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

FAX:                              (512) 459-1552
The Plan will pay benefits on Covered Persons for Covered Expenses as described herein in accordance with the Schedule of Benefits. The Plan provides maximum benefits to the Covered Persons when they:

receive services or treatment from a provider who participates in the Aetna Signature Administrators (ASA) network, a preferred provider organization (PPO); and

follow the procedures of the utilization management program described herein, which is administered by American Health Holding, a utilization management organization.

If you have questions about participating providers or need help finding a participating provider, call Boon-Chapman at (800) 252-9653. A current list of PPO providers is available, without charge, through the Aetna Signature Administrators website (located at www.aetna.com/asa).

If you have questions about the utilization management program, call American Health Holding at (800) 641-5566.

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

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

---

### ACCUMULATORS

<table>
<thead>
<tr>
<th></th>
<th>PPO Providers</th>
<th>Non-PPO Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLES:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Individual Per Calendar Year</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family Maximum Per Calendar Year</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Additional Per Hospital Admission</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>Non-Compliant Penalty</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>OUT OF POCKET MAXIMUMS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Includes Deductibles &amp; Copayments)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Per Individual Per Calendar Year</td>
<td>$7,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family Maximum Per Calendar Year</td>
<td>$21,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>BENEFIT MAXIMUMS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Payable Benefit</td>
<td>UNLIMITED</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$1,500/Calendar Year</td>
<td></td>
</tr>
<tr>
<td>TMJ Treatment</td>
<td>$2,500/Lifetime</td>
<td></td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>$4,000/Lifetime</td>
<td></td>
</tr>
</tbody>
</table>

**PLAN PAYS:** The below percentages are payable AFTER ALL applicable deductible amounts have been satisfied (unless otherwise stated):

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>PPO Providers</th>
<th>Non-PPO Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (For true emergencies)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Ambulance (For non-emergencies)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Chiropractic Care ($1,500/Calendar Year)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Colonoscopy (Routine)</td>
<td>100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>In accordance with USPSTF recommendations</td>
<td>(Deductible waived)</td>
<td></td>
</tr>
<tr>
<td>Diabetic Supply Program – MedWise</td>
<td>100%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
**PLANS PAYS:** The below percentages are payable AFTER ALL applicable deductible amounts have been satisfied (unless otherwise stated):

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<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>PPO Providers</th>
<th>Non-PPO Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes America:</strong> This benefit applies to all covered services (except pharmacy) rendered at any of the Diabetes America healthcare centers.</td>
<td>100% (Deductible waived)</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Diagnostic Lab Services:</strong></td>
<td>100% (Deductible waived)</td>
<td>N/A</td>
</tr>
<tr>
<td>• Preferred Lab Program - <em>Lab Card by Quest</em></td>
<td>100% (Deductible waived)</td>
<td>N/A</td>
</tr>
<tr>
<td>• All Other Lab Providers</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Dialysis – Outpatient</strong> (Pre-certification required)</td>
<td>See section titled “Additional Benefits” for benefits at the end of this Schedule.</td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Emergency Room – Physician &amp; Facility</strong> (For true emergencies)</td>
<td>80%</td>
<td>80%</td>
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<tr>
<td><strong>Emergency Room</strong> (For non-emergencies)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Home Health Care</strong> (Pre-certification required)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Hospice Care - Limited to 6 months of benefits</strong> (Must comply with utilization review to be covered.)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Inpatient (Pre-certification required)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Physician’s Charges</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Human Organ and Tissue Transplants</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>100% (Deductible waived)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Mental and Nervous Care/Substance Abuse</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><em>Contact Interface EAP (800) 324-4327 for your free visits first.</em></td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Physician Visits (Counseling/Medication Checks)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Inpatient Visits (Pre-certification required)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient Visits</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong> (Facility and surgery related charges performed on the same day.)</td>
<td>80% (Deductible waived)</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td>80%</td>
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</tr>
<tr>
<td><strong>Preventive Care, not otherwise specified</strong></td>
<td>100%, deductible waived up to $500/calendar year. Amounts in excess of $500 are subject to regular benefits.</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Second Surgical Opinion</strong></td>
<td>100% (Deductible waived)</td>
<td>100% (Deductible waived)</td>
</tr>
<tr>
<td><strong>Sleep Disorders</strong> ($4,000/Lifetime)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>TMJ Treatment</strong> ($2,500/Lifetime)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>All Other Eligible Expenses</strong></td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*All benefits are subject to “Maximum Eligible Charge” guidelines.*
BUY-UP MEDICAL PLAN (002213A)

SCHEDULE OF MEDICAL BENEFITS – BUY-UP

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

- receive services or treatment from a provider who participates in the Aetna Signature Administrators (ASA) network, a preferred provider organization (PPO); and
- follow the procedures of the utilization management program described herein, which is administered by American Health Holding, a utilization management organization.

If you have questions about participating providers or need help finding a participating provider, call Boon-Chapman at (800) 252-9653. A current list of PPO providers is available, without charge, through the Aetna Signature Administrators website (located at www.aetna.com/asa).

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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Per Individual Per Calendar Year</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>• Family Maximum Per Calendar Year</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>• Additional Per Hospital Admission</td>
<td>$100</td>
<td>$500</td>
</tr>
<tr>
<td>• Non-Compliant Penalty</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>OUT OF POCKET MAXIMUMS:</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Per Individual Per Calendar Year</td>
<td>$3,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Family Maximum Per Calendar Year</td>
<td>$9,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td>BENEFIT MAXIMUMS:</td>
<td>UNLIMITED</td>
<td></td>
</tr>
<tr>
<td>• Overall Payable Benefit</td>
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<td></td>
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<tr>
<td>• Chiropractic Care ($1,500/Calendar Year)</td>
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<td><strong>Colonoscopy (Routine)</strong></td>
<td>100%</td>
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</tr>
<tr>
<td>In accordance with USPSTF recommendations (Deductible waived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Supply Program – MedWise</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Call (800) 596-4465 to have your diabetic supplies shipped to you. (Deductible waived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes America:</strong> This benefit applies to all covered services (except pharmacy) rendered at any of the Diabetes America healthcare centers.</td>
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<td>N/A</td>
</tr>
<tr>
<td>(Deductible waived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Lab Services:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**BUY-UP MEDICAL PLAN (002213A)**

**PLAN PAYS:** The below percentages are payable **AFTER ALL** applicable deductible amounts have been satisfied (unless otherwise stated):

<table>
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<th>Non-PPO Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Preferred Lab Program - <em>Lab Card by Quest</em></td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Deductible waived)</td>
<td></td>
</tr>
<tr>
<td>• All Other Lab Providers</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Diagnostic X-Ray</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Dialysis – Outpatient (Pre-certification required)</td>
<td></td>
<td>See section titled “Additional Benefits” for benefits at the end of this Schedule.</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Emergency Room – Physician &amp; Facility (For true emergencies)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency Room (For non-emergencies)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Home Health Care (Pre-certification required)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Hospice Care - Limited to 6 months of benefits (Must comply with utilization review to be covered.)</td>
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<td>50%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Physician Visits (Counseling/Medication Checks)</td>
<td>100% after $25 copay</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(Deductible waived)</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Visits</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient Visits</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>Outpatient Surgery (Facility and surgery related charges performed on the same day.)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(Deductible waived)</td>
<td></td>
</tr>
<tr>
<td>Physician Office Visit (This copay applies to the Office Visit <em>charge only</em>. All other services, except as specified, are subject to the deductible &amp; coinsurance.)</td>
<td>100% after $25 copay</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(Deductible waived)</td>
<td></td>
</tr>
<tr>
<td>Preventive Care, not otherwise specified</td>
<td>100%, deductible and copay waived up to $500/calendar year. Amounts in excess of $500 are subject to regular benefits.</td>
<td>Not covered</td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(Deductible waived)</td>
<td>(Deductible waived)</td>
</tr>
<tr>
<td>Sleep Disorders ($4,000/Lifetime)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>TMJ Treatment ($2,500/Lifetime)</td>
<td>80%</td>
<td>50%</td>
</tr>
<tr>
<td>All Other Eligible Expenses</td>
<td>80%</td>
<td>50%</td>
</tr>
</tbody>
</table>

*All benefits are subject to “Maximum Eligible Charge” guidelines.*
## DIALYSIS CARVE-OUT BENEFIT

<table>
<thead>
<tr>
<th>OUTPATIENT DIALYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Providers</td>
</tr>
</tbody>
</table>

**Important Note:** The Plan does not use a preferred provider organization (PPO) for dialysis services. The definition of MEC is different for Outpatient Dialysis Services than other services. Please review the definition of “Maximum Eligible Charges” also referred to as “MEC”, which is contained in the Section titled “Definitions” for details.

The Maximum Eligible Charge, for **Outpatient Dialysis Services** provided in connection with the first 40 dialysis treatments while a Covered Person is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider’s normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, is the lesser of:

1. The provider’s normal charge for the same or a similar service or supply; or
2. 125% of what Medicare would allow.

**PRE-CERTIFICATION IS REQUIRED. A Covered Person must:** (1) notify PRIME Dx when Dialysis treatment begins; (2) notify PRIME Dx diagnosed with End Stage Renal Disease (“ESRD”); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.
ENROLLMENT:
The Medicare Supplement Plan is for any Medicare eligible retiree or their dependent(s). Upon Medicare entitlement due to age, these Covered Persons will automatically transition from the full benefit Medical Plan to the Medicare Supplement plan, regardless of a participant’s enrollment in Medicare. See this Plan’s “Additional Coordination of Benefits Rules” section at the end of this Schedule of Benefits.

If a retiree or a retiree’s dependent becomes entitled to Medicare for reasons other than age, you must notify the County immediately to avoid issues with claims payment or benefit verification.

GENERAL INFORMATION:
The Plan will pay benefits on Covered Persons for Covered Expenses as described herein in accordance with the Schedule of Benefits. The Medicare Supplement Plan, in general, provides maximum benefits to the Covered Persons when they:

receive services or treatment from a Medicare participating provider; and

follow all Medicare guidelines and requirements for coverage.

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

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

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>PLAN PAYS…</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICARE PART A</td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospital Expenses</td>
<td></td>
</tr>
<tr>
<td>– 1st 60 days of confinement</td>
<td>Medicare Inpatient Deductible Amount</td>
</tr>
<tr>
<td>– 61st day – 90th day of confinement</td>
<td>¼ Medicare Inpatient Deductible Amount</td>
</tr>
<tr>
<td>– 91st day – 150th day of confinement</td>
<td>½ Medicare Inpatient Deductible Amount</td>
</tr>
<tr>
<td>• Private Room Allowance:</td>
<td></td>
</tr>
<tr>
<td>– Per Day</td>
<td>$5.00</td>
</tr>
<tr>
<td>– Maximum</td>
<td>$150 days</td>
</tr>
<tr>
<td>• First 3 One-Pint Units of Blood:</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>– Per confinement</td>
<td></td>
</tr>
<tr>
<td>• When Medicare Benefits are Exhausted:</td>
<td>80% of the hospital’s most prevalent semi-private room rate</td>
</tr>
<tr>
<td>– Hospital Room and Board</td>
<td></td>
</tr>
<tr>
<td>• Miscellaneous Services and Supplies (not covered by Part B Medicare)</td>
<td>80%</td>
</tr>
<tr>
<td>• Out-of-the-Country Benefits:</td>
<td></td>
</tr>
<tr>
<td>– Inpatient Hospital Expenses</td>
<td>80% of the Medicare Allowable* for room and board and miscellaneous services and supplies</td>
</tr>
<tr>
<td>– Physician Fees</td>
<td>80% of the Medicare Allowable*</td>
</tr>
<tr>
<td>• Non-Medicare Provider</td>
<td>20% of Medicare’s Allowable*</td>
</tr>
<tr>
<td>TYPE OF SERVICE</td>
<td>PLAN PAYS…</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td><strong>MEDICARE PART B</strong></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Hospital and Physician Services</td>
<td>100% of the Part B Deductible; then 20% of the Medicare Allowable*</td>
</tr>
<tr>
<td>• First 3 One-Pint Units of Blood used on an outpatient basis per year:</td>
<td>Paid in Full</td>
</tr>
<tr>
<td>– Thereafter</td>
<td>20% for the remainder of the year</td>
</tr>
<tr>
<td>• Outpatient Psychiatric Care</td>
<td>20% of the Medicare Allowable* until Medicare benefits are exhausted</td>
</tr>
<tr>
<td>– Thereafter</td>
<td>$10.00 per week for treatment</td>
</tr>
<tr>
<td>• Diabetic Supplies through MedWise</td>
<td>100%</td>
</tr>
<tr>
<td>• Non-Medicare Provider</td>
<td>20% of Medicare’s Allowable*</td>
</tr>
</tbody>
</table>

**PRESCRIPTIONS**
(Prescription drug card provided by the County, administered by CVS Caremark)

Please refer to the “PRESCRIPTION DRUG CARD PROGRAM” section of this document for the specific copayments and benefits associated with this program.

**LIMITATIONS:**

The Medicare Supplement benefits are not payable for:

- Amounts paid for by Medicare Parts A and B
- Services or supplies not deemed medically necessary for treatment of an injury or illness
- Any inpatient psychiatric care after the 190th day of confinement
- Care furnished by a health resort, rest home, nursing home, skilled nursing facility or any place providing custodial or rehabilitative care
- Blood or blood plasma which is donated or replaced through any source, or for which no charge is made to the Plan member
- Services and supplies for which benefits are, or could be, provided through:
  - Worker’s Compensation
  - Maritime Doctrine or Maintenance
  - Wages or cure
  - Laws of the United States, any Foreign Country, or any states or political subdivision
  - Veteran’s Administration

**ADDITIONAL COORDINATION OF BENEFITS RULE:**

When a Covered Person reaches Medicare Entitlement, this Plan will pay a benefit equal to secondary coverage to Medicare regardless of that participant’s actual enrollment in Medicare. Therefore, all retired participant’s (including dependents of retirees) are encouraged to enroll in Medicare once you are retired and Medicare eligible.

*In the event a service is not covered by Medicare, but is covered by this Plan, this Plan’s Maximum Eligible Charge rules apply.*
GYM MEMBERSHIP REIMBURSEMENT PROGRAM

<table>
<thead>
<tr>
<th>Program Benefits and Reimbursement Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentive Amount: $40/month</td>
</tr>
</tbody>
</table>

Rules for Participation and Reimbursement:

1. **WHO IS ELIGIBLE?** The County offers this program to all covered employees and retirees. Spouses and dependents are not eligible at this time.

2. **GYMS:** Your gym must have electronic tracking capabilities for monitoring the dates and frequency of your workouts.

3. **WORKOUT FREQUENCY:** You must work out at least nine (9) days per calendar month.

4. **DOCUMENTATION:** You or your gym must be able to produce a printed document from your gym’s electronic tracking system reflecting each day you visited their workout facility. *Handwritten documents will not be accepted.*

5. **FILING FOR REIMBURSEMENT:** After a month in which you met the “Workout Frequency” requirement, you must submit a completed “Reimbursement Form” along with the printed document from your gym (see 1 & 2 above) to Boon-Chapman.

6. **REIMBURSEMENT:** This program will reimburse the employee (who is on a County-sponsored medical plan) the Incentive Amount shown above for each month proper “Documentation” is provided reflecting your complete compliance with these Rules. This is a “reimbursement” program, which means you must pay your membership fee first and then file for reimbursement after you have documentation showing you met all requirements.
ACCUMULATOR PROVISIONS

Deductible
This is the amount of Covered Expenses you pay each Calendar Year before most benefits are paid. There is a Calendar Year Deductible that applies to each Covered Person. An expense Incurred in the last 3 months of a Calendar Year, which is applied against a Covered Person’s Calendar Year Deductible, will reduce the Covered Person’s Calendar Year Deductible for the next year as well. The PPO deductible will also apply to the Non-PPO deductible; however, the Non-PPO amount does not offset the PPO deductible.

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

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

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

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

Exceptions to Plan Co-insurance
The Non-PPO Provider reduced Benefit Percentage will not apply in the following circumstances and such charges will be processed at the stated PPO benefit levels subject to the Maximum Eligible Charge amount:

1. Services rendered by a non-PPO provider for a specialty or service that was not available within the PPO network;
2. Services rendered by a non-PPO ancillary provider (i.e. emergency room physician, radiologists, anesthesiologists, assistant surgeon, on-call specialists, pathologists, etc) in a PPO facility;
3. Emergency services rendered by a Non-PPO provider (ambulance or facility, inpatient or emergency room) when considered Medically Necessary due to an emergency or life threatening condition, as defined by this Plan.
All other Deductibles and benefit limitations apply and payment is based on the Plan’s Maximum Eligible Charges.

**Prescription Drug Program**

A Covered Person may receive benefits for covered prescription drug expenses through the prescription drug program, which allows the Covered Person to present a prescription drug card at a participating pharmacy or a mail order program, and pay the designated copayment. Copayments for the prescription drug card program will not apply to major medical Plan deductibles, but will apply to the Out-of-Pocket Maximum.

**Out-of-Pocket Maximums**

Except as provided below, a Covered Person shall not be required to pay, in one Calendar Year, more than the maximums stated in the Schedule of Benefits as the Out-of-Pocket Maximum the individual or family for Covered Expenses. Once a Covered Person has done so, the Plan will pay all Covered Expenses for the remainder of the Calendar Year.

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

- as a non-compliant penalty because of failure to comply with the utilization management program; or
- because of a benefit maximum.
The prescription drug card program is administered by CVS Caremark. The prescription drug card can be used to purchase prescription drugs at participating pharmacies. To find a participating pharmacy, please contact CVS Caremark at (866) 475-0056 or go to [www.caremark.com](http://www.caremark.com).

The following copayments are payable by the member at the time of service according to the days supply received.

### BASE PLAN

**COPAYMENTS PER PRESCRIPTION:**

<table>
<thead>
<tr>
<th>Retail &amp; Mail-Order Pharmacies</th>
<th>DAYS SUPPLY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-30 days</td>
<td>31-60 days</td>
</tr>
<tr>
<td>Generics</td>
<td>$12</td>
<td>$24</td>
</tr>
<tr>
<td>Brand, Generics Available</td>
<td>$40</td>
<td>$80</td>
</tr>
<tr>
<td>Brand, No Generic Available</td>
<td>$55</td>
<td>$110</td>
</tr>
<tr>
<td>Specialty Medications*</td>
<td>10% up to $125</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

### BUY-UP AND MEDICARE SUPPLEMENT PLANS

**COPAYMENTS PER PRESCRIPTION:**

<table>
<thead>
<tr>
<th>Retail &amp; Mail-Order Pharmacies</th>
<th>DAYS SUPPLY</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-30 days</td>
<td>31-60 days</td>
</tr>
<tr>
<td>Generics</td>
<td>$12</td>
<td>$24</td>
</tr>
<tr>
<td>Brand, Generics Available</td>
<td>$45</td>
<td>$90</td>
</tr>
<tr>
<td>Brand, No Generic Available</td>
<td>$60</td>
<td>$120</td>
</tr>
<tr>
<td>Specialty Medications*</td>
<td>10% up to $130</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Co-pays apply to prescriptions purchased through a participating pharmacy or mail order program. Co-pays for the prescription drug card program do not apply to the member’s medical plan Deductible, but will apply towards the member’s Out-of-Pocket Maximum. If prescription drugs are purchased without using the Plan’s drug card benefit, you must submit to CVS Caremark for reimbursement. Contact Caremark or visit [www.caremark.com](http://www.caremark.com) for more information about the Direct Member Reimbursement process.

*Specialty medications are limited to a 30-day supply and are only covered when purchased through Caremark’s specialty pharmacy. For questions about these medications of the Specialty Pharmacy, please contact CVS Caremark at (866) 475-0056.

Maintenance prescriptions may be purchased through the CVS Caremark mail order program, and are limited to a maximum 90-day supply.

See the section entitled "Eligible Medical Expenses -- Prescription Drugs" for details of this Plan’s prescription drug provisions and limitations.
The Plan’s utilization management (“UM”) program is designed to encourage Covered Persons to obtain quality medical care in a cost-effective manner. The Plan’s UM company is American Health Holding. The UM company does not diagnose or treat medical conditions. You can contact American Health Holding at (800) 641-5566.

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

**Urgent Care Claims**

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

**Pre-Admission Review / Precertification**

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

**Concurrent Care Review**

Except in an Urgent Care Situation, if a Covered Person needs to stay in the Hospital longer than originally authorized, the Covered Person or their healthcare provider must call American Health Holding within 2 business days. The UM company will review the Medical Necessity of the request and notify the individual or the provider whether the additional stay is authorized as Medically Necessary. If the authorization for the additional stay is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits. In an Urgent Care Situation, the Covered Person must notify American Health Holding on the first business day after the additional stay begins.

**Urgent and Emergency Admission Review**

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

**Lower Level Care Admission**

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

**Review of Outpatient Services**

The Covered Person or their healthcare provider is required to obtain prior approval at least three business days before any of the following scheduled procedures or services are rendered:

- Dialysis;
- Home Health Care;
- Hospice Care;

While precertification is not required, it is recommended that the Covered Person or their healthcare provider obtain prior approval from Boon-Chapman at least three business days before any of the following scheduled procedures or services are rendered:

- Blepharoplasty;
- Carpal tunnel Surgery;
- Chemotherapy- initial treatment and/or changes to initial treatment plan;
- CT scans (Computerized Tomography);
- Durable Medical Equipment (rental or purchase) if the cost exceeds $1,000;
- MRI’s (Magnetic Resonance Imaging);
- Physical, occupational, or speech therapy; or
- Septoplasty.

In an Urgent Care Situation a covered person must contact American Health Holding on the first business day after receiving services. If authorization is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits.

**Case Management**

American Health Holding will also provide case management services to those members with catastrophic illnesses, chronic diseases, acute episodes of illness, traumatic injuries or individuals requiring multiple healthcare services.
A Covered Person must call American Health Holding within 30 days of learning that she is pregnant. In addition, a Covered Person must call American Health Holding within five days of becoming a possible candidate for an organ transplant.

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

If a Covered Person contacts American Health Holding in accordance with these provisions, but does not follow American Health Holding’s recommended course of treatment, then benefits will not be reduced provided the services received are Medically Necessary.

In an Urgent Care Situation a Covered Person must contact American Health Holding on the first business day after receiving services. If American Health Holding is not contacted in accordance with these provisions, then Covered Expenses will be reduced as described in the Schedule of Benefits for non-compliance. If a Covered Person contacts American Health Holding in accordance with these provisions, but does not follow American Health Holding’s recommended course of treatment, then benefits will not be reduced provided the services received are Medically Necessary.

Second Opinion

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

Plan Administrator Utilization Management Discretion

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

Effect of Obtaining an Authorization

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

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

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

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

Allergy Testing

Ambulance
For emergency transportation (within the Continental United States) of the Covered Person to the nearest hospital where care and treatment of the injury or illness can be given, or other medical institution for necessary special treatment not locally obtainable and which is considered a medical necessity.

Ambulatory Surgical Center/Licensed Surgical Facility

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

Assistant Surgeon
The Plan will cover charges by an assistant surgeon when Medically Necessary due to the nature of the procedure being performed. The Plan will allow up to twenty-five percent (25%) of the primary surgeon’s Covered Expenses and are payable according to the network status of the primary surgeon.

Birthing Centers

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

Braces, Crutches, Casts, Splints, Trusses, and Surgical Dressings

Chemical Dependency
See the definition of Mental and Nervous Care/Substance Abuse. Also see the Schedule of Benefits for possible limitations.

Chemotherapy
Chiropractic Care

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

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

Drug or Substance Abuse
See "Chemical Dependency."

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

Hearing Aids
Hearing aids and the examination for the prescription when an injury to the internal ear or illness results in permanent hearing loss.

Home Health Care
Covered expenses are limited to those for services listed herein that are furnished by a home health care agency to a covered person who is under the care of a physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending physician, and the orders must be renewed at least every 30 days. The attending physician must also certify that the proper treatment of the sickness or accidental injury would require confinement as a resident in-patient in a hospital or skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

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

- a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);
- home health aides under supervision of a R.N.;
- physical, occupational, and speech therapists; or
- a licensed midwife.

You must be certified as homebound by your physician. To be homebound means the following:

- Leaving your home is not recommended because of your condition;
- Your condition keeps you from leaving home without help (such as needing special transportation, using a wheelchair or walker, or getting help from another person);
- Leaving home takes a considerable and taxing effort.

A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as attending religious services. You can still get home health care if you attend adult day care, but you would get the home care services in your home.

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

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

- nursing care by a licensed registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed vocational nurse (L.V.N.), or a public health nurse who is under the direct supervision of a licensed registered graduate nurse (R.N.);
- medical services, supplies, and drugs; or
- Physician’s services.

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

Hospital Services
Covered Expenses include:

- daily room and board charges based on the Semi-private Room Charge;
- private room charges will be covered if Medically Necessary by the patient highly susceptible to contracting another Illness by being in a semi-private room or patient is contagious; and
- all other Medically Necessary services and supplies furnished by the Hospital, but not for private-duty nursing care.

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

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

Immunizations and vaccinations

Laboratory Tests

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

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

Mental Health Care
See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.
Midwife
Services of a registered nurse midwife.

Morbid Obesity
Surgical and non-surgical treatment of morbid obesity. "Morbid Obesity" means body weight is twice the ideal body weight (IBW) as determined by standard accepted national tables or 100 pounds over the IBW, or body mass index (BMI) value of greater than 40.

Charges for surgical and non-surgical morbid obesity treatment must be preauthorized and is subject to all of the following guidelines:

a. The patient’s body weight is twice the ideal body weight (IBW) as determined by standard accepted national tables or 100 pounds over the IBW, or body mass index (BMI) value of greater than 40.

b. The patient has a health problem, which is related to the obesity and which may ultimately be life threatening (such as severe hypertension, sleep apnea, congestive heart disease, or insulin dependent diabetes).

Non-surgical weight loss treatment of morbid obesity is covered with respect to physician office visits, prescribed diet medication, and consultations with a registered licensed dietitian regarding eating education. Items such as weight loss instructions or memberships from commercial weight loss programs; exercise programs or activities or equipment; over-the-counter-drugs or appetite suppressants; or books would not be covered.

Gastric restrictive or surgical procedures for morbid obesity are covered subject to the additional following provisions:

A medical review service used by the Plan determines that the surgery meets the following criteria:

1. Patient has at least six (6) months of repeated and well documented weight loss efforts that have failed within the last two (2) years. Such weight loss efforts must be in a structured or physician-supervised programs that are medically balanced and safe. As an example, the patient should have been through at least six (6) months of documented efforts in structured weight loss programs (including counseling) which have resulted in no weight loss or minimal weight loss with at least an 80% attendance record.

2. Absence of medical co-morbidity that makes surgical intervention too risky or hazardous.

3. The surgical facility and physician performing the procedure has substantial experience with surgical treatment of obesity, is willing to provide (upon request) documented outcomes and provides an appropriate aftercare program for medical management and counseling. The program should include treatment for nutritional and psychiatric counseling as part of a multi-disciplinary approach to treating patients being considered for surgery and for patients post surgery.

4. The patient must have full understand and acceptance (through written acknowledgment) of the high risks associated with gastric restrictive surgery, that the surgery itself may not be a long term solution for weight loss, and the surgery may result in other potentially serious medical complications.

Due to the extreme nature of this surgical procedure and the high risk of complications, a second surgical opinion is recommended from a physician who performs bariatric surgery, as to the necessity of the surgery, the type of surgery to be performed and the place performed as to being able to handle any complications that may arise.

Multiple Surgical Procedures
Multiple surgical procedure allowances are specified below:

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

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

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

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

Separate operative area: maximum eligible charge or negotiated fee.

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

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

Observation Room Services
In order for an observation stay (a period not to exceed 48 hours) to be considered medically necessary, the following conditions must be met:

- The patient is clinically unstable for discharge; and
- Clinical monitoring, and/or laboratory, radiologic, or other testing is necessary in order to assess the patient’s need for hospitalization; or
- The treatment plan is not established or based upon the patient’s conditions, is anticipated to be completed within a period not to exceed 48 hours; or
- Change in status or condition are anticipated and immediate medical intervention may be required.

Observation room services are not covered when the above criteria are not met. Observation services that extend beyond a 48-hour period are not covered. Providers must contact Boon Chapman and obtain approval for inpatient status for services beyond the initial 48-hour period.

The following is a list of services that are not considered appropriate for observation room services (this list is not all-inclusive):
- Services are not reasonable or necessary for the diagnosis and treatment of the patient
- Outpatient blood or chemotherapy administration
- Lack of/delay in patient transportation
- When used as a substitute for inpatient admission or services would normally require inpatient stay
- When it is provided only as a convenience for the physician, patient or patient’s family
- While waiting for transfer to another facility
- When inpatients discharged to observation status

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

Oxygen
Oxygen, and services and supplies up to the purchase price required for the administration of oxygen.

**Pathology**

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

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

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

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

**Pregnancy**
Pregnancy expenses are covered to the same extent as any other Sickness.

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

**Prescription Drugs**
Covered prescription drug expenses are limited to those for:

- drugs which have been approved by the FDA;
- prescription legend drugs (i.e., any medicinal substance whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription");
- contraceptives;
- contraceptive devices;
- compound medications, of which at least one ingredient is a prescription legend drug;
- prescribed prenatal legend vitamins;
- any other drugs that under the applicable state or federal law may be dispensed only upon the written prescription of a Physician; and
injectable insulin, including disposable insulin needles or syringes, or other injectable drugs which have been approved by the FDA;

and do not include those expenses for:

tretinoin, all dosage forms (e.g. Retin-A), for individuals 26 years of age or older;

Nicorette or any other drug containing nicotine or other smoking-deterrent medications, except in conjunction with participation in a County-sponsored tobacco cessation program;

anorectics (drugs used for the purpose of weight control);

vitamins (singly or in combination);

Rogaine (minoxidil);

dietary supplements;

fluoride supplements;

non-legend drugs other than insulin;

charges for the administration or injection of any drug;

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

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

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

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

infertility medications;

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

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

Preventive Care Services

The preventive care benefit shown in the Schedule of Benefits are limited to the following routine services:

- Mammogram
- Pelvic Exam
- Prostate Exam
- PSA (prostate specific antigen test)
- Electrocardiogram (EKG)
- SMAC (sequential multiple analyzer chemicals test)
- PAP Smear
- Cholesterol screening
- Chest x-ray
- Urinalysis
- CBC (complete blood count)
- Well-baby check-ups
- Charges incurred for an office visit during which any of these above services are provided.

All other preventive services are subject to regular benefits.

**Prosthetic Limbs, Eyes or Other Appliances**
Covered Expenses are limited to those for:

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

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

a replacement Prosthesis necessitated by the growth of a child.

**Radiation Therapy**
Radium and radioactive isotope therapy.

**Radiology and X-rays**

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

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

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

**Sleep Disorders Treatment**
Covered Expenses are limited to treatment of apnea and narcolepsy, subject to the maximum benefit stated in the Schedule of Benefits.

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

Temporomandibular Joint Dysfunction (TMJ) – Surgical Treatment Only
Expenses related to other methods of treatment will not be covered, such as Orthodontics. See the Schedule of Benefits for possible limitations.

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

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

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

If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by a donor who is not ordinarily covered under this Plan according to participant eligibility requirements will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan.

Transportation costs of any organ will be considered an eligible expense.

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

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

Vision Care
Covered Expenses are limited to the initial purchase of glasses or contact lenses required as treatment of a medical condition, such as following cataract surgery.
MEDICAL LIMITATIONS AND EXCLUSIONS

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

Abortion
Elective abortion unless the mother's life would be in substantial danger if the Pregnancy were allowed to continue to term. Complications arising out of an abortion, however, are covered as any other Sickness.

Acupuncture or Acupressure
Unless administered by an M.D. or D.O.

Adoption Expenses

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

Biofeedback

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

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

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

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

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

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

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

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

Hair Transplants

Hearing Aids or Related Examinations
Except as described under Eligible Medical Expenses.

Hypnosis

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

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

Massage Therapy or Rolfing

Nicotine Addiction
Charges related to treatment of nicotine addiction.

Obesity
See "Weight Control."

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

Penile Prosthetic Implant

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

Psychiatric Testing, Counseling, or Therapy
Except as may be specifically provided herein, the Plan does not cover psychiatric or psychological testing or evaluation (unless specifically related to the treatment of a psychiatric condition), hypnotherapy, or marriage or family counseling (when there is not an identified patient); treatment of learning disorders, mental retardation, or autism of childhood; vocational testing, evaluation, or counseling; or therapy or counseling for sexual dysfunctions or inadequacies.

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

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

**Sterilization Reversal**
Expenses Incurred for the reconstruction (i.e. reversal) of any sterilization procedure.

**Surrogate Expenses**

**Vision Care**
Eye examinations and refractions for the purpose of prescribing corrective lenses, eyeglasses, or contact lenses or the fitting thereof.

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

**Weight Control**
Services or supplies for obesity, weight reduction, or dietary control, except as shown under Morbid Obesity.

**Wigs, Artificial Hair Pieces and Maintenance**
GENERAL HEALTH CARE COVERAGE EXCLUSIONS

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

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

- necessary due to a non-occupational Accidental Injury;
- necessary for correction of post-surgical deformity.

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

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

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

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

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

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

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

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

Late-Filed Claims
Claims that are not filed with the Contract Administrator no later than March 31st of the year following the date the expense is Incurred.

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

Missed Appointments
Expenses incurred for failure to keep a scheduled appointment.

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

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

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

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

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

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

Travel
Unless approved by the utilization management organization.

Veteran's Hospital
See "Government-Operated Facilities."

War
Medical or dental conditions resulting from insurrection, war (declared or undeclared), or any act of war and any complications there from, or service in the armed forces of any country.
Work-Related Injury or Sickness
Any injury or sickness that is caused by, or connected in any way to employment of the covered person. (This includes self employment or employment by others. It applies whether or not workers' compensation or similar law covers the expenses incurred.)
COORDINATION OF BENEFITS

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

Definitions

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

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

- group, blanket, or franchise insurance coverage;
- group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);
- group Blue Cross and Blue Shield coverage;
- group automobile insurance;
- individual auto insurance based upon the principles of no-fault coverage;
- any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;
- any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or
- any group coverage sponsored by or provided through a school or other educational institution.

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

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

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

Effect on Benefits Under This Plan

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

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

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

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

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

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

**Order of Benefit Determination**

Each plan determines its order of benefits using the first of the following rules that apply. These rules establishing the order of benefit determination are:

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

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

- when Claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or

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

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

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

  - the plan of the parent not having custody of the child will be determined third; or
if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

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

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

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

**Right to Receive and Release Necessary Information**

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

**Treatment of Medicare Benefits**

Medicare is the program of medical care benefits provided under Title XVIII of the Social Security Act.

Individuals who have earned the required number of quarters for Social Security benefits within the specified timeframe are eligible for Medicare Part A at no cost. Ineligible individuals age 65 and over may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B is available to all individuals who pay the full cost of coverage. A voluntary prescription drug benefit (Part D) to the Medicare program is available to “Part D individuals,” which Medicare defines as individuals who have coverage under Medicare Part A or Part B and who live in the service area of a Part D plan.

Federal legislation requires that active Employees age 65 and over be given the option to elect either the Employer’s plan or Medicare as primary coverage. If the affected Employee elects this Plan as primary coverage, the regular benefits of this Plan will apply. If an Employee elects Medicare as primary coverage, no benefits will be available under this Plan.

Federal legislation also requires that an active Employee’s spouse who is age 65 or over be given the option to elect the Employer’s plan or Medicare as primary coverage. If the affected spouse elects the benefits of this Plan as primary coverage, the regular benefits of this Plan will apply. If the spouse elects Medicare as primary coverage, no benefits will be available under this Plan.

The Plan is the primary payer and Medicare is the secondary payer for services that would have been covered by Medicare in each of the following situations:

- an Employee or Dependent spouse of an Employee covered under this Plan because of current employment who is entitled to Medicare benefits due to age;

- an Employee or Dependent covered under this Plan as a result of current employment who is entitled to Medicare benefits because of total disability;
an Employee or Dependent who is entitled to Medicare because of end stage renal disease until the end of the Medicare secondary coordination period.

Benefits for Participants who are eligible for Medicare benefits will be paid according to the Health Care Financing Administration rules and regulations coordinating Medicare with group health plans. This Plan will pay secondary in all instances allowed by HCFA and the Medicare Secondary Payer provisions of the Social Security Act.

When Medicare is the primary payer and an Employee or Dependent entitled to Medicare incurs Hospital, surgical or other charges covered under Medicare and other charges which are not covered under Medicare, this Plan’s benefits will cover charges incurred to the extent that they are not covered under Medicare. All of the Coordination of Benefits provisions will apply, including the provision that states that a Managed Care Participant will receive benefits under this Plan at a level that is secondary to the benefits of the Managed Care Option (for example, Medicare Plus Choice) would have provided had the Participant utilized a participating and/or network provider.

Special Provisions with Respect to Medicare

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

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

IMPORTANT NOTICE: A retiree covered under This Plan who becomes Medicare eligible will automatically be converted from the full benefit plans of the County to the Medicare Supplemental Plan, regardless of actual enrollment in any Medicare plan. Dependents of the retiree who are not Medicare eligible will remain on the full benefit plan unless and until they become Medicare eligible or otherwise lose their eligibility for the Plan.
SUBROGATION AND REIMBURSEMENT

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

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

The Covered Person must:
Execute and deliver a Subrogation and Reimbursement Agreement;

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

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

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

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

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan’s right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.
The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

**Amount Subject to Subrogation or Reimbursement**
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys’ fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all charges and expenses.

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

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

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

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

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

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

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

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

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

Eligibility Requirements — Employees
"Employee" shall mean a person who is a regular full-time or half-time employee of the Employer as defined by the Employer and is regularly scheduled to work in an employer-employee relationship. For purposes of the Plan, seasonal, temporary and leased employees will not be deemed to be "Employees."

In order to be an "Eligible Employee," so that he is eligible to participate in the health care coverages of the Plan, an Employee must complete a Waiting Period of the first day of the month following 30 days. An Employee shall be deemed to be benefit-eligible if he is absent from work due to a health factor. However, in order to be eligible to participate in the Plan, the Employee must begin work for the Employer. If the Employee is unable to do so, then coverage will become effective on such later date when he actually begins work.

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

This Plan may provide contributory coverage (each Employee pays a part of the cost of coverage). An Eligible Employee's coverage is effective, subject to conditions set forth above, upon completion of the forms for such purpose.

If an Employee fails to enroll within 30 days of the Employee’s date of hire, the Employee's coverage will be effective only if enrolled under the special enrollment provision or if enrolled during an Annual Enrollment.

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

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

a child until the last day of the month following their 26th birthday (including any natural child, legally adopted child or a child placed for adoption with Employee; a stepchild; a foster child or child for whom the Employee has legal guardianship).

An "Eligible Dependent" does not include:

any person who is on active duty in a military service;

any person who is covered as an Employee under the Plan;

any person who is covered as a Dependent of another Employee under the Plan.

Family Status Change (Mid-Year Changes)
Except as provided later in this section, an Employee’s elections may not be changed during the Plan Year for which the election is effective, and participation in the Plan by any Employee may not commence other than at the beginning of a Plan Year or within thirty (30) days of an Employee’s eligibility with respect to newly-eligible Employees, unless such change, or participation is on account of and consistent with one of the following changes in status:
a. Change in status events:

1. Legal marital status. Events which change the Employee’s legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment.

2. Number of dependents. Events which change the Employee’s number of Dependents, including birth, adoption, placement for adoption, or death of a Dependent.

3. Employment status. A termination or commencement of employment by Employee, Employee’s spouse or Employee’s Dependent.

4. Work schedule. A reduction or increase in hours of employment by Employee, Employee’s spouse, or Employee’s Dependent, or commencement or return from an unpaid leave of absence.

5. Dependent status. An event that causes Employee’s Dependent to satisfy or cease to satisfy requirements for coverage under the Plan due to attainment of age.

6. Residence or worksite. A change in the place of residence or work of Employee, Employee’s spouse, or Employee’s Dependent that affect eligibility for benefits under the plan.

b. Other changes in circumstances:

1. Qualified Medical Child Support Orders (QMCSO). In the event of the entry of a qualified medical child support order, an Employee may change the election if the order requires coverage of the child or may cancel coverage if the order requires the former spouse to provide coverage. See “Qualified Medical Child Support Orders” later in this section for additional details and timelines that apply in these situations.

2. Medicare/Medicaid. If Employee, Employee’s spouse, or Employee’s Dependent becomes eligible for Medicare or Medicaid (other than coverage solely for distribution of pediatric vaccines), Employee may cancel coverage for Employee, Employee’s spouse, or Employee’s Dependent as the case may be for the Plan.

3. Special Enrollment Rights. If a Participant is entitled to special enrollment rights under a group health plan and medical coverage was declined under the group health plan because of outside coverage which is subsequently lost or a new Dependent is acquired, then a Participant may revoke a prior election for coverage and make a new election, provided the election corresponds with such special enrollment right. See “Special Enrollment” later in this section for additional details and timelines that apply in these situations.

4. Coverage Change of Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the same employer or another employer) if (i) the other plan permits participants to make an election change that would be permitted under the plan of the other employer or (ii) the periods of coverage under the Participant’s plan are different from the periods of coverage under the plan of the other employer.

5. Change Due to Cost or Coverage Changes. If the Participant’s cost for coverage significantly increases or decreases during the Plan Year, or the Plan substantially changes or eliminates coverage,
the Participant may make a corresponding change in election under the Plan for the balance of the Plan Year.

A Participant may make such a change in elections only if a change in status event (a) results in a gain (or loss) of coverage under the Plan and such change is on account of and consistent with the change in status.

**Effective Date and Timing of Notice**

The proper application requesting a change must be submitted to the Plan Administrator no later than 30 days following such change in status. If such application is not submitted within the 30-day period (or other timeline required under the “Special Enrollment” section) after a change in status, the change will not be permitted until the next Annual Enrollment for an effective date of the beginning of the following Plan Year. For all timely made changes in status, except the acquiring of new dependents, coverage will become effective the first of the month following completion of application.

**Qualified Medical Child Support Orders**

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

**Alternate Recipient** shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

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

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

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

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipient(s)); and

4. Identity of an underlying child support order.

**Qualified Medical Child Support Order** is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:
1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

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

1. Contains the information set forth above in the definition of “National Medical Support Notice”;

2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or

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

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

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

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

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

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

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   (a) Whether the child is covered under the Plan; and

   (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

**Effective Date — Dependents**

Subject to the Plan’s special enrollment provisions, an Eligible Dependent will be covered beginning with the later of the following dates, provided the Employee makes written application for coverage for such Dependent in a form furnished by the Plan Administrator or Contract Administrator for that purpose within 30 days of Dependent’s initial eligibility and the Employee has agreed to pay any required contribution for such coverage:

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

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

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

**Special Enrollment**

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

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

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

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

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

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

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

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

another individual (a spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form within 30 days of the marriage, birth, adoption or placement for adoption.

Enrollment in the Plan will be effective on the date (1) of the Employee’s marriage; (2) of the new Dependent’s birth; or (3) of the new Dependent’s adoption or placement for adoption with the Employee.

Annual Enrollment
Eligible Employees may enroll for coverage during Annual Enrollment Periods. Coverage for Eligible Employees enrolling during an Annual Enrollment Period will become effective on January 1, unless the Employee has not satisfied the Waiting Period or has not yet begun work for the Employer, in which event coverage for the Employee and the Employee’s Eligible Dependents will become effective on the day following completion of the Waiting Period or the day the Employee actually begins work. “Annual Enrollment Period” is established by the employer and generally is held during the month of October each Plan Year.

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

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

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

Reinstatement of Coverage
A. Following Voluntary Termination of Employment:
   A terminated Employee who is rehired within 30 days will not be treated as a new hire and will be reinstated with no lapse. A terminated Employee who is rehired after 30 days will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

B. Following a Medical Leave or Personal Leave of Absence:
If Plan coverage terminated during the FMLA leave, coverage will be reinstated for the Employee and covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated to the same extent that it was in force when that coverage terminated.

C. Following Active Military Duty:
With respect to any Plan Participant who receives orders to perform active duty in the Armed Forces of the United States, such person shall, upon resumption of employment, be immediately restored to the same eligibility status the Plan Participant held as of the last day the Plan Participant was actively-at-work, provided all of the following conditions are met:

1. The Plan Participant must have left employment for the purpose of entering active duty; and
2. The Plan Participant must apply for re-employment within:
   a. Thirty (30) days after release from active duty if activated under the Presidential call-up authority; or
   b. Ninety (90) days after release from active duty in all other cases; and
3. The Plan Participant’s total amount of active duty (other than training duty) cannot exceed five years, unless extended by the period of time the President authorizes the call-up of reserve units or individuals, or the individual is unable to obtain orders for release from active duty.

TCDRS Qualifying Retiree Determination
Refer to the “Continuation of Coverage as a Retiree” section.
TERMINATION OF COVERAGE

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

- the date of termination of the Plan;
- the last day of the month following termination of participation in the Plan by the Employee;
- the day prior to the date of Employee's entry into the armed forces of any country;
- the date of expiration of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (the Employee shares in the cost);
- the last day of the month on which the covered Employee leaves or is dismissed from the employment of the Employer; and
- the last day of the month in which the Employee ceases to be eligible for coverage under the Plan.

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

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

- the date of termination of the Plan;
- the date coverage for Dependents terminates under the Plan;
- the date the Dependent becomes covered as an Employee under the Plan;
- the date of termination of the coverage of the Employee;
- the date the Covered Person no longer satisfies the Plan's definition of Dependent; or
- the date of expiration of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (the Employee shares in the cost).

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

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

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

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

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

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

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

The Employee must submit to the Contract Administrator proof of the child's incapacity within 30 days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Family and Medical Leave Act of 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the employer for at least twelve (12) months, and have performed at least 1,250 hours of service with the employer in the twelve (12) months immediately preceding the start of the leave.

B. Reasons for FMLA Leave

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

1. The birth of a son or daughter, in order to care for that son or daughter.

2. The placement of a son or daughter with you for adoption or foster care.

3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.
4. Because of a serious health condition that makes you unable to perform the functions of your position.

5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:

   a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and

   b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member’s office, grade, rank, or rating.

6. A qualifying exigency due to your spouse, son, daughter, or parent’s active duty status, or notification of an impending call to active duty status, in support of a contingency operation.
CONTINUATION OF COVERAGE OPTION (COBRA)

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

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

Definitions

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

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

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

Notification

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

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

Election and Election Period

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

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

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

**Effective Date of Coverage**

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

**Level of Benefits**

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

**Cost of Continuation of Coverage**

Except as provided below, the cost of coverage may be paid in monthly installments, and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of election of continuation of coverage hereunder. Thereafter, payments are due on the 1st day of each month to continue coverage for that month. If a payment is not made within 30 days of the due date, coverage will be cancelled and will not be reinstated.

**Termination of Continuation of Coverage**

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

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

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

- the termination of all group health plans provided by the Plan Sponsor;
the failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is
more than 30 days delinquent in paying premium);

the date the Qualified Beneficiary is covered under any other group health plan, as a result of employment,
re-employment, or remarriage; and

the date the Qualified Beneficiary becomes entitled to Medicare benefits.

**Keep Your Plan Informed of Address Changes**

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

**Certificates of Coverage**

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

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

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

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

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

Right to Continue Coverage

An Employee who is approved for retirement as a TCDRS Qualifying Retiree can continue coverage on the Plan provided there is no break in coverage (with the exception of an FMLA break in accordance with Federal Law) whether the continued coverage is through active employment or COBRA coverage during the TCDRS determination period, unless at the time of retirement the retiree is eligible for group health benefits through other employment of their own. This provision for continuing coverage only applies to the Covered Employee and any Dependents covered on the applicable Plan prior to this date. If a TCDRS Qualifying Retiree has not had continuous coverage from their last date of active employment through their TCDRS determination period, their coverage will not be reinstated.

In addition, a Covered Employee who, on the date of retirement from the County, is eligible for retirement under TCDRS regulations but chooses to remain a non-depositing member of TCDRS, can continue on the Plan for themselves and any Dependents provided such continuation complies with the Human Resources policy manual.

To receive continued coverage under this Plan, the retiree must inform the Employer that they elect to continue coverage no later than the day on which the person retires.

Level of Coverage

The Qualifying Retiree may elect to cover the same persons who were covered under the Plan at the time of retirement, or the Qualifying Retiree may elect to discontinue coverage for one or more persons. If the person elects to continue coverage for themselves and their Covered Dependents and later elects to discontinue such coverage, coverage cannot later be reinstated for such person(s). Any person (including dependents, whether newly acquired or not) who was not covered under the Plan at the time of retirement is not eligible for coverage under this Plan.

Qualifying Retirees that are Medicare eligible will be provided the Medicare Supplement Plan. Any Covered Dependents of a Qualifying Retiree who is Medicare eligible will also be provided the Medicare Supplemental Plan.

A Qualifying Retiree and any Covered Dependents may continue their coverage at the same or reduced level of coverage as was in effect prior to the date of retirement. Coverage cannot be increased at any time on or after retirement.

Changes in Coverage After Retirement

A Retiree may reduce their coverage or level of benefits during the Plan’s Annual Enrollment Period or within 30 days of a Special Enrollment Event.

Payment for Coverage

Retirees are required to pay their monthly premiums (when applicable) to the County by the first of each month for the month in which the coverage is for. However, payment will not be accepted later than the last day of the said month.
CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE

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

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

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

The Plan does not require preauthorization of any service in an Urgent Care Situation, so there are no Urgent Care Claims under the Plan. Consequently, under the Plan, there are three types of claims: Pre-service Non-urgent Care, Concurrent Care and Post-service.

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

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

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

When Health Claims Must Be Filed
Health claims must be filed with the Contract Administrator no later than March 31st following the year in which the Covered service was Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

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

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

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

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Care Claims, of decisions that a claim is payable in full) within the following timeframes:

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

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

Concurrent Care Claims

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

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

Post-service Claims
If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

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

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

**Calculating Time Periods**
The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

**Notification of an Adverse Benefit Determination**
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request); and
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

**Appeals of Adverse Benefit Determinations**

**Full and Fair Review of All Claims**
In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:
1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. That a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant’s claim for benefits in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows:

Pre-service Non-urgent Claims: **American Health Appeals Department**
7400 West Campus Road, F-510
New Albany, OH 43054
Fax Number: 866-881-9643

Post-service Claims: **Boon Chapman Benefit Administrators, Inc.**
Attention: Appeals
P.O. Box 9201
Austin, TX 78766
Fax Number: 512-459-1552.

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

1. The name of the Employee/Claimant;
2. The Employee/Claimant’s social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise
factual arguments and theories, which support this claim if the Claimant fails to include them in the appeal;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Appeal
The Plan Administrator shall notify the Claimant of the Plan’s benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

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

Post-service Claims
Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal.
The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan’s adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant’s claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant’s medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

**Furnishing Documents in the Event of an Adverse Determination.**
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

**SECOND APPEAL LEVEL**

**Adverse Decision on First Appeal; Requirements for Second Appeal**
Upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a “full and fair review” of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as the Claimant had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing marked “Personal & Confidential” to Human Resources, Galveston County, 722 Moody Avenue, 3rd Floor, Galveston, Texas 77550 and must include all of the items set forth in the section entitled "Requirements for First Appeal."

**Timing of Notification of Benefit Determination on Second Appeal**
The Plan Administrator shall notify the Claimant of the Plan’s benefit determination on review within the following timeframes:

**Pre-service Non-urgent Care Claims**
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

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

**Post-service Claims**
Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

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

**Manner and Content of Notification of Adverse Benefit Determination on Second Appeal**
The same information must be included in the Plan’s response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

**Furnishing Documents in the Event of an Adverse Determination**
In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.
Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

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

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

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

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

Affordable Care Act
The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, and subsequent guidance issued thereunder.

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

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

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

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

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

has organized facilities for birth services on its premises; and

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

Business Associate shall generally have the same meaning as the term “business associate” at 45 CFR 160.103, and in reference to the party to this Plan, shall mean Boon-Chapman Benefit Administrators, Inc.
**Calendar Year**
The period of time commencing at 12:01 a.m. on January 1 of each year and ending at 12:00 midnight on the next December 31. Each succeeding like period will be considered a new Calendar Year.

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

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

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

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

**Co-insurance**
See the Schedule of Benefits.

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

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

**Covered Entity** shall generally have the same meaning as the term “covered entity” at 45 CFR 160.103, and in reference to the party to this plan, shall mean [Insert Name of Covered Entity].

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

**Covered Person**
A covered Employee, a covered Dependent, or a COBRA Qualified Beneficiary.

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

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

**Deductible**
See the Schedule of Benefits, including the Accumulator Provisions, for information.

**Dental Hygienist**
A person who is licensed to practice dental hygiene, practicing within the scope of their license, and not a member of your Immediate Family.

**Dental Practitioner**
A Dentist, Dental Hygienist, or Denturist.

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

**Denturist**
A person who is licensed to make, fit, or repair dentures, practicing within the scope of their license, and not a member of your Immediate Family.

**Dependent**
See "Eligibility and Effective Dates."

**Dialysis Services**
Dialysis services means any service, supply, equipment or drug utilized in connection with hemodialysis or peritoneal dialysis.

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

- can withstand repeated use;
- are primarily and customarily used to serve a medical purpose;
- generally are not useful to a person in the absence of Sickness or Accidental Injury; and
- are appropriate for use in the home.

**Employee**
See "Eligibility and Effective Dates."

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

**Essential Health Benefits**
Includes (1) ambulatory services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and
chronic disease management; and (10) pediatric services, including oral and vision care, as determined by the Plan Administrator in accordance with the Affordable Care Act.

**Health Breach Notification Rule** shall mean 16 CFR Part 318.

**HIPAA Rules**

**Home Health Care Agency**
An agency or organization that:

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

**Hospice Care Program**
An entity:

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

**Hospital**
An institution that:

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

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

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

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

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

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

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

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

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

**Illness**

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

**Immediate Family**

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

**Incurred**

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

the date a purchase is contracted;

the date delivery is made; or

the actual date a service is rendered.

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

With respect to dental services, expenses shall be deemed to be “Incurred” on the date that the service or treatment is performed, except for the following services or treatments:

- dentures or bridgework – the date the impressions are taken;

- crowns, inlays, onlays, - the date the teeth are first prepared;
root canal therapy – the date the pulp chamber is opened; and

active orthodontic care – the date the appliances are inserted.

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

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

**Maximum Eligible Charge (MEC)**
Maximum Eligible Charge is an amount determined in the discretion of the Plan Administrator or its delegate using any one of the following:

- A fee that was negotiated with the Provider;
- A fee determined using a national relative value scale;
- A fee determined using a percentage of what Medicare would allow for the service or supply;
- A fee determined using an industry accepted fee database; or
- A fee determined using a percentage off billed charges.

The Maximum Eligible Charge, for Outpatient Dialysis Services provided in connection with the first 40 dialysis treatments while a Covered Person is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider’s normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, is the lesser of:

1. The provider’s normal charge for the same or a similar service or supply; or
2. 125% of what Medicare would allow.

With regard to charges made by a provider of service participating in the Plan’s PPO program, “Maximum Eligible Charge” shall mean the rates negotiated between the preferred provider organization and the participating providers unless services have otherwise been specifically excluded from the PPO reimbursement arrangement in the Schedule of Benefits.

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

To be Medically Necessary, Covered Expenses must:

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

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

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

it is provided only as a convenience to the Covered Person or provider;

it is not appropriate treatment for the Covered Person's diagnosis or symptoms;

it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or

it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;

is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or

is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

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

The sources of information to be relied upon are:

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

a Covered Person's medical records;

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

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

Mental and Nervous Care/Substance Abuse
Such term includes treatment for mental and nervous disorders or conditions, as accepted by the general psychiatric community, including treatment for substance abuse.

Mental Illness (Serious)
Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

- schizophrenia;
- paranoid and other psychotic disorders;
- bipolar disorders (hypomanic, manic, depressive, and mixed);
- major depressive disorders (single episode or recurrent);
- schizo-affective disorders (bipolar or depressive);
- pervasive developmental disorders;
- obsessive-compulsive disorders; and
- depression in childhood and adolescence.

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

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

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

Orthodontic Treatment
The movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Outpatient
Services rendered on other than an Inpatient basis.

PHI
Protected Health Information, as enacted pursuant to HIPAA.
Physician
A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

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

- Dentist (D.D.S. or D.M.D.);
- Optometrist (O.D.);
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.);
- Psychologist (Ph.D.); and
- Chiropractor (D.C.).

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

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

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

Plan
The Galveston County Health Protection Plan.

Plan Administrator
See "Administrative Information" Section.
Plan Document
This Plan Document and Summary Plan Description, which shall serve as both the Plan Document and the Summary Plan Description.

Plan Sponsor
See "Administrative Information" Section.

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

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

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

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

Protected Health Information (PHI)
Any information that identifies an individual, or reasonably could be used to identify an individual.

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

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

Skilled Nursing Facility
An institution that:

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

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

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

- admits patients only upon the recommendation of a Physician;

- maintains complete medical records;

- has the services of a Physician available at all times; and
is not, other than incidentally, a nursing home, a hotel, a school, or a similar institution, a place of rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

**Spouse**
A legal spouse meeting all the requirements of a valid marriage contract in the state of marriage.

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

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

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

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

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

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

Funding - Sources and Uses

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

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

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

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

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

Administrative Provisions

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

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

If the Plan Administrator decides to pay such benefits in one instance, it shall not be obligated to provide the same or similar benefits in any other instance, nor shall such action be deemed to be a continuing waiver unless specifically stated therein.
Plan Administrator
The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

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

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

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

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.
Annual Statements
If required by law, the Plan Sponsor shall furnish to each Employee, within a reasonable period of time following
the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor
for Plan benefits during the prior Plan Year.

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

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or
the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not
limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or
judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise
limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this
Plan Document.

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

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

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

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

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

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

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

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

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

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

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

Physical Examination and Autopsy
The Plan Administrator, at its own expense, shall have the right and opportunity to have a Physician of its choice
examine the Covered Person when and as often as it may reasonably require during the pendency of any claim and
to make an autopsy in case of death, where it is not forbidden by law.
Reimbursements
Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor shall be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

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

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

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

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

Workers’ Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by workers’ compensation insurance laws or similar legislation.
HIPAA PRIVACY RULE AND SECURITY STANDARDS

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

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

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

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

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

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the “504” provisions;

2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and

3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

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

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

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

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

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

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members’ Protected Health Information received from the Plan (or from the Plan’s health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.
The Plan sponsor will not use or disclose members’ Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

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

Notify participants of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule (16 CFR Part 318);

Notify the Federal Trade Commission of any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule (16 CFR Part 318)

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

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

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

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

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

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

The Plan sponsor will obtain authorization prior to the sale of any Protected Health Information;

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

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

**Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor**
The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. Modifying, amending, or terminating the Plan.

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

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

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

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

1. Human Resources Staff Members
2. Information Technology
3. Treasurer’s Office
4. Auditor’s Office
5. County Attorney’s Office

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

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

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

A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s Electronic Protected Health Information; and

2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan’s request.

3. Notify participants of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule (16 CFR Part 318);

4. Notify the Federal Trade Commission of any PHI Security Incident of which the Plan Sponsor, or any Business Associate of the Plan Sponsor becomes aware, in accordance with the health breach notification rule (16 CFR Part 318).