

PPO ACTIVE - GRANDFATHERED

City of Murfreesboro
HEALTH BENEFIT PLAN

Plan Document and Summary Plan Description

Effective: September 1, 2008

Restated: July 1, 2011

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ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by City of Murfreesboro (hereinafter referred to as "Plan Administrator" or "Plan Sponsor") as of July 1, 2011, hereby **amends and restates** the City of Murfreesboro Health Benefit Plan (the "Plan"), which was originally adopted by the Plan Sponsor, effective September 1, 2008.

1.01 Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

City of Murfreesboro

By: _____

Name: _____

Date: _____

Title: _____

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, Retirees and Long Term Disabled (LTD) Enrollees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, Retirees and LTD Enrollees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital, medical, or prescription benefits. The Plan Document is maintained by the City of Murfreesboro and may be inspected at any time during normal working hours by any Participant.

2.02 General Plan Information

Patient Protection and Affordable Care Act

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 Sponsor at the following address:

City of Murfreesboro
111 West Vine Street
Murfreesboro, TN 37133

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Name of Plan: **City of Murfreesboro Health Benefit Plan**

Plan Sponsor: **City of Murfreesboro**
111 West Vine Street
Murfreesboro, TN 37133
615-848-2553

Plan Administrator: **City of Murfreesboro**
(Named Fiduciary) **111 West Vine Street**
Murfreesboro, TN 37133
615-848-2553

Plan Sponsor ID No. (EIN): 62-6000374

Source of Funding: Self-Funded

Applicable Law: Federal
State of Tennessee

Plan Year: July 1 through June 30

Plan Type: Medical
Prescription Drug

Third Party Administrator: HealthSCOPE Benefits, Inc.
27 Corporate Hill Drive
Little Rock, AR 72205
501-225-1551

Participating Employer: City of Murfreesboro

Agent for Service of Process: City of Murfreesboro
City Attorney
111 West Vine Street
Murfreesboro, TN 37133
615-848-2553

2.03 Legal Entity; Service of Process

Legal notice may be filed with, and legal process served upon, the Plan Sponsor.

2.04 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Employer and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

2.05 Mental Health Parity

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Sponsor.

2.06 Applicable Law

When applicable, Federal law and jurisdiction preempt State law and jurisdiction.

2.07 Discretionary Authority

The Plan Sponsor shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

“Accident”

“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”

“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“Actively At Work” or “Active Employment”

“Actively At Work” or “Active Employment” shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan’s Allowable Expenses shall consist of the Plan Participant’s responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

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

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered.

“Birthing Center”

“Birthing Center” shall mean a facility that meets professionally recognized standards and all of the following requirements:

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has the following: at least 2 delivery rooms; all the medical equipment needed to support the services furnished by the facility; laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening situations.
3. It has medical staff that: is supervised by a Physician on a full-time basis; and includes a Registered Nurse at all times when Covered Persons are at the facility.
4. If it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre or post-natal care.
5. It admits only Covered Persons who: have undergone an educational program to prepare them for the birth; and have medical records of adequate prenatal care.
6. It schedules confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

“Cardiac Care Unit”

“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Centers of Excellence”

“Centers of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Sponsor shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Certificate of Coverage”

“Certificate of Coverage” shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child”

“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

“CHIP”

“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”

“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”

“Chiropractic Care” shall mean office visits, x-rays, manipulations, supplies, heat treatment, and cold treatment.

“Claim Determination Period”

“Claim Determination Period” shall mean each calendar year.

“Clean Claim”

A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Sponsor may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

“COBRA”

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Cosmetic Surgery”

“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

“Covered Expense”

“Covered Expense” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

“Covered Mental Health Service Providers”

“Covered Mental Health Service Providers” are Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals. Office visits are limited and subject to the Summary of Benefits and other terms and provisions of this document.

“Creditable Coverage”

“Creditable Coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

“Custodial Care”

“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”

“Deductible” shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required. **Deductibles accrue toward the 100% maximum out-of-pocket payment.** Covered expenses incurred in, and applied toward, the Deductible in the last three months of a calendar year by a Participant and Family Unit will be applied toward the Deductible in the next calendar year.

“Dentist”

“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”

“Dependent” shall mean one or more of the following person(s):

1. An Employee or Retired Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee or Retired Employee. For purposes of this section, “marriage or married” means a legal union between one man and one woman as husband and wife;

2. An Employee or Retired Employee's Child who is less than 26 years of age, who is not eligible to participate in their own employer's medical plan or their spouse's employer's medical plan;
3. An Employee or Retired Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee or Retired Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Sponsor, which establishes a Dependent relationship.

"Detoxification"

"Detoxification" shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

"Diagnostic Service"

"Diagnostic Service" shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

"Disease"

"Disease" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

"Drug"

"Drug" shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a currently licensed Physician.

"Durable Medical Equipment"

"Durable Medical Equipment" shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

“Elimination Period”

“Elimination Period” shall mean the interval of time after the Retired Employee retires from employment with his or her Participating Employer.

“Emergency”

“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”

“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”

“Emergency Services” shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

“Employee”

“Employee” shall mean a person who is a regular full-time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an employer-Employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered “full-time.”

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis; or
3. if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
 - a) maximum tolerated dose;
 - b) toxicity;
 - c) safety;
 - d) efficacy; and
 - e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. A clinical study or review article in a reviewed professional journal.

The Plan Sponsor retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”

“Family Unit” shall mean the Employee, his or her spouse and Children.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

“FMLA Leave” shall mean a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

“Health Breach Notification Rule”

“Health Breach Notification Rule” shall mean 16 CFR Part 318.

“HIPAA”

“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”

“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

“Home Health Care Agency”

“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
 - b. It has a full-time administrator;
 - c. It maintains written records of services provided to the patient;
 - d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - e. Its employees are bonded and it provides malpractice insurance.

“Hospital”

“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Illness”

“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”

“Impregnation and Infertility Treatment” shall mean artificial insemination and in-vitro fertilization, whether or not such procedure is successful.

“Incurred”

“Incurred” shall mean that a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

“Injury”

“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”

“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

“Institution”

“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

“Intensive Care Unit”

“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Late Enrollee”

“Late Enrollee” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan;
or
2. Through a special enrollment qualified event.

“Leave of Absence”

“Leave of Absence” shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

“Long Term Disability (LTD) Enrollee”

“Long Term Disability (LTD) Enrollee” shall mean a Participant who has met the eligibility standards and who has been approved to receive a benefit from the employer's disability carrier.

“Mastectomy”

“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Amount” or “Maximum Allowable Charge”

“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

“Medically Necessary”

“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant’s Sickness or Injury without adversely affecting the Plan Participant’s medical condition.

- A) It must not be maintenance therapy or maintenance treatment.
- B) Its purpose must be to restore health.
- C) It must not be primarily custodial in nature.
- D) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
- E) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “Medically Necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that any other services are deemed to be “Medically Necessary.”

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Sponsor’s own medical advisors. The Plan Sponsor has the discretionary authority to decide whether care or treatment is Medically Necessary.

“Medically Necessary Leave of Absence”

“Medically Necessary Leave of Absence” shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational institution that:

1. Commences while such Dependent is suffering from a serious Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

“Medical Record Review”

“Medical Record Review” is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in

the billing, then the Plan Sponsor may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

“Medicare”

“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)

“Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or Nervous Disorder”

“Mental or Nervous Disorder” shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

“National Medical Support Notice” or “NMSN”

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

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

“Network”

“Network” shall mean the medical provider network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participant’s identification card.

“No-Fault Auto Insurance”

“No-Fault Auto Insurance” is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

“Non-Occupational Injury”

“Non-occupational Injury” shall have the meaning set forth in the definition of “Injury.”

“Non Network Fee Schedule (NNFS)”

“Non Network Fee Schedule (NNFS)” is a fee schedule used to re-price non-network claims.

“Open Enrollment Period”

“Open Enrollment Period” shall mean the period of time designated for enrollment in the Plan as determined by the Plan Sponsor in each year.

“Other Plan”

“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers’ compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Participant” / “Plan Participant”

“Participant” shall mean any Employee or Dependent who is eligible for benefits under the Plan.

“Physician”

“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”

“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-admission Tests”

“Pre-admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Pregnancy”

“Pregnancy” shall mean carrying a child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Pre-existing Condition”

“Pre existing Condition” is any Sickness, Illness, Disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a Provider or practitioner duly licensed to provide such care under applicable State law and operating within the scope of practice authorized by such State law, during the six months immediately prior to the date an Employee’s Service Waiting Period commences (the “Enrollment Date”).

Coverage will be available for such condition on the day immediately following the expiration of 12 months or, in the case of a Late Enrollee, 18 months after the Enrollment Date. A Participant has the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

“Privacy Standards”

“Privacy Standards” shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”

“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Sponsor.

“Psychiatric Hospital”

“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Reasonable”

“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Sponsor, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Sponsor retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Sponsor. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Rehabilitation Hospital”

“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Room and Board”

“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

“Scheduled benefit” or “Scheduled benefit amount” means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of scheduled benefit amounts may be found in the section, “Summary of Benefits”. A complete listing of scheduled benefit amounts may be obtained on the web site at www.healthscopebenefits.com.

Scheduled benefit amounts are determined taking into consideration (but not restricted to) the lesser of the Usual and Customary fee for services and/or supplies, which are deemed to be both Reasonable and Medically Necessary, and:

- For inpatient hospital expenses, the Medicare Diagnosis Related Group (“DRG”) scheduled dollar conversion amounts based upon the CMS weighted values.
- For outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values.
- For physicians and other eligible Providers, scheduled benefit amounts, the lesser of the scheduled benefit amount or [125%] of the CMS Reimbursement Schedule for the CMS area.
- For Ambulatory Surgical Centers (ASC) the lesser of the scheduled benefit amount or [125%] of the CMS Reimbursement Schedule for the CMS area.
- At the Plan Sponsor’s discretion, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.
- If the Plan Sponsor is unable to determine scheduled benefit amounts utilizing the aforementioned process, it shall, at its sole discretion, determine scheduled benefit amounts considering accepted industry-standard documentation uniformly applied without discrimination to any Plan Participant.

“Security Standards”

“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Service Waiting Period”

“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active full-time Employment of his or her Participating Employer. The Employee will be eligible for coverage on the first day of the month following or coinciding with the day of completion of the Service Waiting Period of 90 days of service for the Plan Sponsor.

“Sickness”

“Sickness” shall have the meaning set forth in the definition of “Disease.”

“Significant Break in Coverage”

“Significant Break in Coverage” shall mean a period of 63 consecutive days during each of which an individual does not have any Creditable Coverage.

“Substance Abuse”

“Substance Abuse” shall mean a psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

“Substance Abuse Treatment Center”

“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”

“Surgery” shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Sponsor may, in its sole discretion, require.

“Totally Disabled”

“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”

“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”

“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Usual and Customary”

“Usual and Customary” (U&C) shall mean covered expenses which are identified by the Plan Sponsor, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Sponsor will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Sponsor’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE IV ELIGIBILITY FOR COVERAGE

4.01 Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following or coinciding with the date of completion of a Service Waiting Period of 90 days of service for the Plan Sponsor. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

An Employee who is receiving a long term disability benefit and who was employed with the Plan Sponsor a minimum of 90 days prior to becoming disabled and was covered by the Plan at the time the Employee became disabled is eligible for coverage. At age 65 a Retiree, a long term disability enrollee, and his or her spouse will no longer be eligible for coverage under the Plan, but may be offered coverage under the Medicare supplement plan if the benefit is available for participation. Coverage will terminate at age 65 for an individual who did not complete 15 years of continuous service for the Plan Sponsor and who was not continuously covered under the Plan Sponsor's health plan for 5 years.

4.02 Eligibility for Retiree Coverage

A person is eligible for Retiree coverage from the first day that he or she:

1. Is a Retired Employee of the Employer and not eligible for Medicare;
2. Has attained age 55 (but has not yet reached age 65), completed 15 years of continuous service with the Plan Sponsor and had 5 years continuous coverage in the Plan Sponsor's health plan; or
3. Has completed 30 years of continuous service with the Plan Sponsor, regardless of age, and had coverage under the Plan Sponsor's health plan for 5 years prior to retirement.

Coverage under the Plan will terminate for a Retired Employee who did not complete 15 years of continuous service for the Plan Sponsor and who was not continuously covered under the Plan Sponsor's health plan for 5 years.

A Retired Employee who attains age 65 or becomes eligible for Medicare (whichever occurs first) will no longer be eligible for coverage for himself or herself and the Retired Employee's spouse under the Plan but may be offered coverage under the Medicare supplement plan if the benefit is available for participation.

An Employee must enroll for coverage by filling out and signing an enrollment application. The enrollment will be "timely" if the completed form and the first month's premium is received by the Plan Sponsor no later than 31 days after the person becomes eligible for coverage (termination date as an Active Employee).

4.03 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

4.04 Eligibility for Survivor Coverage

A person is eligible for coverage if he or she is the surviving spouse (who has not remarried) or dependent child of an Employee who had worked a minimum of 15 years for the Plan Sponsor and had family coverage under the Plan at the time of death.

Coverage for the surviving spouse may continue until he or she: reaches age 65; remarries; goes to work full time; or becomes eligible for Medicare, whichever occurs first. At age 65, the surviving spouse may be offered coverage under the Medicare supplement plan if it is offered by the Plan Sponsor if he or she was participating in the Plan immediately prior to reaching age 65.

4.05 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Sponsor and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Sponsor within the 31-day period immediately following the date of eligibility.
2. Coverage for New Dependents. Coverage for a Dependent acquired by reason of marriage, birth, legal adoption, placement for adoption, or court or administrative order shall take effect on the date of the event giving rise to dependent status. Coverage is effective only if the Plan Sponsor receives required documentation and is notified of the event within 31 days of its occurrence.
3. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
4. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
5. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
6. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

4.06 Special Enrollment

The Plan provides special enrollment periods that allow Employee's to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

4.06A A Special Enrollment for Previously Enrolled Participants

Dependents who had ceased to be eligible to enroll in the Plan prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a 30-day Special Enrollment opportunity. This Special Enrollment opportunity will begin May 15, 2011. All Dependents whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of Dependent coverage of Children ended before age 26, are eligible to enroll, or re-enroll in the plan or coverage under this Special Enrollment period. Coverage for Dependents who enroll through this Special Enrollment opportunity must take effect no later than July 1, 2011.

Participants who were previously enrolled, but were terminated from Plan participation because of a prior lifetime limitation provision shall be provided with a 30-day Special Enrollment opportunity. This Special Enrollment

opportunity will begin May 15, 2011. Participants whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because a prior lifetime limitation provision, are eligible to enroll, or re-enroll in the plan or coverage under this Special Enrollment period. Coverage for Participants who enroll through this Special Enrollment opportunity must take effect no later than July 1, 2011.

4.06B Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost. For example, if the Employee loses his or her other health coverage on July 1, he or she must notify the Plan Sponsor and apply for coverage by close of business on August 1.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

4.06C New Dependent

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 31 days after he or she acquires the new Dependent. For example, if the Employee is married on July 1, he or she must notify the Plan Sponsor and apply for coverage by close of business on August 1.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the date of the marriage;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

4.06D Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

4.06E Open Enrollment

Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on July 1, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

“**Open Enrollment Period**” shall mean the period of time designated for enrollment in the Plan as determined by the Plan Sponsor in each Plan Year.

4.06F Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled “Effective Dates of Coverage; Conditions,” will apply to Participants enrolling during a Special Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the date of the qualified event giving rise to the Special Enrollment.

4.07 National Medical Support Notice

“**National Medical Support Notice**” or “**NMSN**” shall mean a notice that contains the following information:

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

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

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

4.08 Special Restrictions for Pre-existing Conditions

A Pre-existing Condition limitation will apply for all Employees and Dependents entering or reentering the Plan after the Effective Date, except as set forth in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). No coverage is provided for expenses in connection with a Pre-existing Condition.

A “**Pre-existing Condition**” is any Sickness, Illness, Disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care Provider or practitioner duly licensed to provide such care under applicable State law and operating within the scope of practice authorized by such State law, during the six months immediately prior to the date an Employee’s Service Waiting Period commences (the “Enrollment Date”).

Coverage will be available for such condition on the day immediately following the expiration of 12 months or, in the case of a Late Enrollee, 18 months after the Enrollment Date. A Participant has the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

The Pre-existing Condition limitation does not apply to any Participant or Dependent that has not yet reached age 19.

“**Late Enrollee**” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

4.08A Proof of Creditable Coverage

A Participant may prove Creditable Coverage by either of two methods:

1. For Creditable Coverage effective on or after July 1, 1996, the Participant may present a written Certificate of Coverage from the source or entity that provided the coverage showing:
 - a. The date the Certificate was issued;
 - b. The name of the group health plan that provided the coverage;
 - c. The name of the Participant or Dependent to whom the Certificate applies;
 - d. The name, address, and telephone number of the plan administrator or issuer providing the Certificate;
 - e. A telephone number for further information (if different);
 - f. Either:
 - (1) A statement that the Participant or Dependent has at least 18 months (546 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
 - (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and
 - g. The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate; or

2. If the Participant for any reason is unable to obtain a Certificate from another plan (including because the Creditable Coverage was effective prior to July 1, 1996), he or she may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party Provider. This Plan will treat a Participant as having provided a Certificate if that individual:
 - a. Attests to the period of Creditable Coverage;
 - b. Presents relevant corroborating evidence of some Creditable Coverage during the period; and
 - c. Cooperates with the Plan Administrator's efforts to verify his or her status.

A Participant has the right to request a Certificate from his or her prior health plan, and the Plan Administrator will help the Participant in obtaining the Certificate.

4.08B Notice of Pre-existing Condition Exclusion

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

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

4.08C Pre-existing Condition Exception

With respect to a Qualified Plan Participant who elects COBRA Continuation Coverage pursuant to the American Recovery and Reinvestment Act of 2009 and the Department of Defense Appropriations Act, 2010, the following periods shall be disregarded for purposes of determining the 63-day break in coverage period, as referred to in Section 701(c)(2) of ERISA:

1. The period beginning on the date of the Qualifying Event; and
2. The period ending with the start of COBRA Continuation Coverage.

Any Participant or Dependent that has not yet reached the age of 19 is not subject to the Pre-existing Condition limitation(s) described herein.

4.09 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

4.10 "GINA"

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

ARTICLE V TERMINATION OF COVERAGE

5.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The last day of the month following termination of the Plan;
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date;
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. The last day of the month in which the termination of employment occurs; or
6. The last day of the month in which an Employee or his or her Dependent submits, or has knowledge of the submission of, a claim involving fraud or misrepresentation or provides any information involving fraud or misrepresentation to the Plan, including enrollment information.

5.02 Termination Dates of Retiree Coverage for Retiree, Retiree's Spouse, LTD Enrollee and Dependents

The coverage of any Retiree, LTD Enrollee, his or her spouse and Dependents who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The date of death of the covered Retiree or LTD Enrollee;
3. The date of the expiration of the last period for which the Retiree or LTD Enrollee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing; or
4. The date the covered Retiree becomes eligible for Medicare coverage. If eligibility requirements are met, the Medicare eligible individual may transfer to the Medicare Supplement Plan.

5.03 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The last day of the month in which there is discontinuance of coverage for Dependents under the Plan;
3. For minor Dependents only: the last day of the month in which there is termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The last day of the month in which such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a claim involving fraud or misrepresentation or provides any information involving fraud or misrepresentation to the Plan, including enrollment information.

5.04 Certificates of Coverage

The Plan generally will automatically provide a Certificate of Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is or has been covered under the Plan.

ARTICLE VI CONTINUATION OF COVERAGE

6.01 Continuation During FMLA Leave

Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

6.01A Eligible Employees

Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Participating Employer for at least 12 months;
2. The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

6.01B Qualifying Circumstances for FMLA Leave

Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Son or Daughter;
2. The placement of a Child with the Employee for adoption or foster care;
3. The Employee's taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;
4. The Employee's taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or
5. A Qualifying Exigency arising out of the fact that a Spouse, Son or Daughter, Parent, or Next of Kin of the Employee is a regular or reserve component in the Armed Forces.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a service member following a Serious Illness or Injury to that service member, when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin; or
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran's Spouse, Son or Daughter, Parent, or Next of Kin.

This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

The Employee's premium contribution will continue to be deducted from any accrued time used during FMLA leave. If no accrued time is available, premiums will be made up each pay period until paid in full by payroll deductions upon the Employee's return to work.

6.01C Notice Requirements

An Employee must provide at least 30 days' notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee's request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

6.01D Length of Leave

During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

6.01E Termination of FMLA Leave

Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Participating Employer of his or her intent not to return from leave;
2. When the employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When the Employee fails to return from the leave;
4. The Participating Employer and/or Plan Sponsor is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for *COBRA* continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

6.01F Recovery of Plan Contributions

The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee's control.

6.01G Reinstatement of Coverage

The law requires that coverage be reinstated upon the Employee's return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.

On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period and the Pre-existing Condition limitation will be credited as if the Employee had been continually covered under the Plan.

6.01H Definitions

For this provision only, the following terms are defined as stated.

“Next of Kin”

“Next of Kin” shall mean the nearest blood relative to the service member.

“Parent”

“Parent” shall mean the Employee’s biological parent or someone who has acted as his or her parent in place of his or her biological parent when he or she was a Son or Daughter.

“Qualifying Exigency”

“Qualifying Exigency” shall mean:

1. Short-notice deployment.
 - a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
 - b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;
2. Military events and related activities.
 - a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
 - b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;
3. Childcare and school activities.
 - a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
 - b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
 - c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
 - d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;
4. Financial and legal arrangements. To make or update financial or legal arrangements to address the covered military member’s absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority,

enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust; and

5. Counseling. To attend counseling provided by someone other than a health care Provider for oneself, for the covered military member, or for the biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;
6. Post-deployment activities.
 - a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member's active duty status; and
 - b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and
7. Additional activities. To address other events which arise out of the covered military member's active duty or call to active duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

“Serious Health Condition”

“Serious Health Condition” shall mean an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care Provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the State in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

“Serious Illness or Injury”

“Serious Illness or Injury” shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties.

“Son or Daughter”

“Son or Daughter” shall mean the Employee's biological child, adopted child, stepchild, foster child, a child placed in the Employee's legal custody, or a child for which the Employee is acting as the parent in place of the child's natural blood related parent.

“Spouse”

“Spouse” shall mean an Employee's husband or wife.

NOTE: For complete information regarding FMLA rights, contact the Participating Employer.

6.02 Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. If a Participant elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue coverage, Participants must comply with the terms of the Plan and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating employer for information concerning their eligibility for USERRA and any requirements of the Plan.

6.03 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

6.04A COBRA Continuation Coverage

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer’s plan) are not considered for continuation under COBRA.

6.04B Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Plan Participant.” The Employee, the Employee’s spouse, and the Employee’s dependent children could become Qualified Plan Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason **other than gross misconduct**.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse’s hours of employment are reduced;
3. The spouse’s employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent children will become Qualified Plan Participants if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee’s hours of employment are reduced;
3. The parent-covered Employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to City of Murfreesboro, and that bankruptcy results in the loss of coverage of any retired employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Plan Participant with respect to the bankruptcy.

6.04C Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Sponsor of the Qualifying Event.

6.04D Employee Notice of Qualifying Events

Each covered Employee or Qualified Plan Participant is responsible for providing the Plan Sponsor with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Sponsor is:

City of Murfreesboro
Human Resources Director
111 West Vine Street
Murfreesboro, TN 37133
615-848-2553

A form of notice is available, free of charge, from the Plan Sponsor and must be used when providing the notice.

6.04E Deadline for providing the notice

For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Sponsor.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Sponsor.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or

2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Sponsor.

The notice must be postmarked (if mailed), or received by the Plan Sponsor (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

6.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

6.04G Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Sponsor may request additional information. If the individual fails to provide such information within the time period specified by the Plan Sponsor in the request, the Plan Sponsor may reject the notice if it does not contain enough information for the Plan Sponsor to identify the plan, the covered Employee (or former employee), the Qualified Plan Participants, the Qualifying Event or disability,

and the date on which the Qualifying Event, if any, occurred.

6.04H Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Sponsor within 14 days **of receiving the notice of the Qualifying Event**. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Sponsor determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Sponsor will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

6.04I Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee’s (or former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child’s losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

6.04J Disability Extension of COBRA Continuation Coverage

If an Employee or anyone in an Employee’s family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Sponsor as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

6.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee’s family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving

COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

6.04L Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant's failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) except as stated under COBRA's special bankruptcy rules. However, a Qualified Plan Participant who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

6.04M Contribution and/or Premium Requirements

Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

6.05 Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Sponsor, who is:

City of Murfreesboro
Human Resources Director
111 West Vine Street
Murfreesboro, TN
615-848-2553

6.06 Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the Plan Sponsor (who is identified above) informed of any changes in the addresses of family members.

ARTICLE VII GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

Custodial Care. That do not restore health, unless specifically mentioned otherwise;

Error. That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Sponsor, in its sole discretion, unreasonably gave rise to the expense;

Excess. That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Sponsor's determination as set forth by and within the terms of this document;

Experimental. That are Experimental or Investigational;

Illegal acts. For any Injury or Sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);

Family Member. That are performed by a person who is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of "blood" or "in law";

Incurred by Other Persons. For expenses actually incurred by other persons;

Medical Necessity. That are not Medically Necessary;

Medicare. For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare;"

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

No Legal Obligation. That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage;

Not Acceptable. That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;

Not Actually Rendered. That are not actually rendered;

Not Specifically Covered. That are not specifically covered under this Plan;

Other than Attending Physician. Other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider;

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Prohibited by Law. To the extent that payment under this Plan is prohibited by law;

Provider Error. Required as a result of unreasonable provider error;

Subrogation, Reimbursement, and/or Third Party Responsibility. Of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions; and

War. Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any Country, or during service by a Participant in the armed forces of any Country. This exclusion does not apply to any Participant who is not a member of the armed forces.

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.

ARTICLE VIII PLAN ADMINISTRATION

The Plan is administered by the Plan Sponsor. The Plan Sponsor has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

8.01 Plan Administrator

The Plan is administered by the Plan Administrator, who is the Plan Sponsor, within the purview of applicable laws, and in accordance with these provisions. 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 Participant'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 Participant is entitled to them.

The Plan Administrator has delegated Plan administration duties to its Human Resources Director, and may delegate such duties to such other person or persons as it deems convenient or necessary, but the ultimate responsibility for Plan administration and interpretation shall remain with the Plan Administrator.

8.02 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 Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required;
10. To establish and communicate procedures to determine whether a medical child support order 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.

8.03 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 Mayor and City Council, 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 the Trust Agreement (if any). This includes amending the benefits under the Plan. Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

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

ARTICLE IX CLAIM PROCEDURES; PAYMENT OF CLAIMS

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

9.01 Health Claims

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

Each Participant 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 Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post-service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan’s design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. **Pre-service Claims.** A “Pre-service Claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim.” The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures

with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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

9.01A When Claims Must Be Filed

Claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) were incurred. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan’s procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Third Party 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, which reflect any applicable PPO re-pricing;
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 initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

9.01B Timing of Claim Decisions

Upon receiving a Clean Claim, the Third Party Administrator on behalf of the Plan Sponsor shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims.
 - a. If the Participant 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.
 - b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant 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 Participant will be notified of a determination of benefits within 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 Sponsor and the Participant (if additional information was requested during the extension period).
2. Concurrent Claims:
 - a. Plan Notice of Reduction or Termination. If the Plan Sponsor is notifying the Participant 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 Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - b. Request by Participant Involving Urgent Care. If the Plan Sponsor receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
 - c. Request by Participant Involving Non-urgent Care. If the Plan Sponsor receives a request from the Participant 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).
3. Post-service Claims:
 - a. If the Participant has provided a Clean 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.
 - b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant 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 Participant will be notified of the determination by a date agreed to by the Plan Sponsor and the Participant.

4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Sponsor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, 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.
5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Sponsor both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, 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.
6. 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.

9.01C Notification of an Adverse Benefit Determination

The Third Party Administrator on behalf of the Plan Sponsor shall provide a Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), 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 Participant 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 Participant 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 Participant'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 Participant, free of charge, upon request);
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 Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

9.02 Appeal of Adverse Benefit Determinations

9.02A Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. 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 Participant relating to the claim, without regard to whether such information was submitted or considered in the 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; or
7. That a Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Sponsor or the Third Party 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 Participant's medical circumstances.

9.02B Requirements for Appeal

The Participant must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination.

To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims:

Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

**HealthSCOPE Benefits
Attn: Appeals
P.O. Box 2860
Little Rock, AR 72203**

It shall be the responsibility of the Participant 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/Participant;
2. The Employee/Participant'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 Participant will lose the right to raise factual arguments and theories which support this claim if the Participant 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 Participant has which indicates that the Participant is entitled to benefits under the Plan.

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

9.02C Timing of Notification of Benefit Determination on Review

The Third Party Administrator on behalf of the Plan Sponsor shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent 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.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
4. 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.

9.02D Manner and Content of Notification of Adverse Benefit Determination on Review

The Third Party Administrator on behalf of the Plan Sponsor shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, 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 summary plan description 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 Plan Participant 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 Plan Participant'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 Plan Participant 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 Plan Participant's medical circumstances, will be provided free of charge upon request;
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

9.02E Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Third Party Administrator on behalf of the Plan Sponsor shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

9.02F Decision on Review to be Final

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Sponsor 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.**

9.03 Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Sponsor or the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant's medical condition to act as the Participant's authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Sponsor, in writing, to the contrary.

9.04 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

9.05 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.06 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

9.06A Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

9.06B Non U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;

3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

9.06C Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Sponsor has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Sponsor shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Sponsor shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Sponsor shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Sponsor may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Sponsor or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;

4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

9.06D Medicaid Coverage

A Participant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

ARTICLE X COORDINATION OF BENEFITS

10.01 Benefits Subject to This Provision

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

10.02 Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

- a) Any primary payer besides the Plan;
- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Workers' compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.03 Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

10.04 Allowable Expenses.

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan's Allowable Expenses shall consist of the Plan Participant's responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

10.05 "Claim Determination Period"

"Claim Determination Period" shall mean each calendar year.

10.06 Effect on Benefits:

10.06A Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of this Plan's Allowable Expenses. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

10.06B Order of Benefit Determination

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. The primary plan will pay or provide its benefits as if the secondary plan does not exist;
2. A plan without a coordinating provision will always be the primary plan. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a plan to provide out-of-network benefits;
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan;
4. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent; then the order of benefits between the two plans is reversed so that the plan covering the person as an employee or retiree is secondary and the other plan is primary;
5. Child Covered Under More Than One Plan. The order of benefits for a child who is covered by more than one plan is:
 - The primary plan is the plan of the parent whose birthday is earlier (month and day of birth, not year) in the year if:
 - The parents are married;
 - The parents are not separated (whether or not they have ever been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.
 - If the parents are not married, or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the noncustodial parent; and then
 - The plan of the spouse of the noncustodial parent.
6. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
7. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
8. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between all plans under this regulation. In addition, this Plan will not pay more than it would have paid had it been primary.

10.07 Right to Receive and Release Necessary Information

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

10.08 Facility of Payment

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

10.09 Right of Recovery

In accordance with section 9.06C, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. **Please see 9.06C above for more details.**

ARTICLE XI MEDICARE

11.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

11.02 Applicable to Active Employees and Their Dependents (Under Age 65) Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

11.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

12.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).
2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

12.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
 - a) The responsible party, its insurer, or any other source on behalf of that party;

- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Workers' compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

12.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

12.04 Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- a) The responsible party, its insurer, or any other source on behalf of that party;
- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Workers' compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

12.05 Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

12.06 Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

12.07 Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - b) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - c) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - d) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - e) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - f) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

12.08 Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

12.09 Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

12.10 Language Interpretation

1. The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice.

12.11 Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XIII MISCELLANEOUS PROVISIONS

13.01 Applicable Law

When applicable, Federal law and jurisdiction preempt State law and jurisdiction.

13.02 Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

13.03 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 Sponsor 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.

13.04 Fraud

The following actions by any Participant, or a Participant'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 Participant 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 Participant of the Plan;
2. Attempting to file a claim for a Participant 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.

13.05 Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

13.06 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.

13.07 Plan 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 Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Sponsor shall be free to determine the manner and means of funding the Plan. The amount of the Participant's contribution (if any) will be determined from time to time by the Plan Sponsor.

13.08 Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Sponsor may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Sponsor shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Sponsor such information as may be necessary to implement this provision.

13.09 Written Notice

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

13.10 Right of Recovery

In accordance with 9.06C, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. **See 9.06C above for full details.**

13.11 Statements

All statements made by the Company or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

ARTICLE XIV SUMMARY OF BENEFITS

14.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. **“Utilization Management”** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled “Cost Containment.”

The following services will require pre-certification (or reimbursement from the Plan may be reduced):

- Inpatient Hospitalization;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
- Home Health Services;
- Durable Medical Equipment, rental greater than 2 months, or purchase in excess of \$500 billed per date of service;
- Rehab program (such as Cardiac, Chemical Dependency, Pain Management, Pulmonary);
- Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Therapy;
- Inpatient Mental/Nervous facility based programs;
- Skilled Nursing Facility stays;
- MRI/CT/PET Scans; and
- Dialysis.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have your Physician call to obtain pre-certification in case there is a need to have a longer stay.

See pre-certification requirements in the section entitled “Cost Containment” for more details.

Notification is requested for the following services:

- 23-hour observation stays;
- Outpatient surgical facility;
- Hospice services;
- Infusion services;
- Dialysis; and
- High-tech radiology services.

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called “Network Providers.” Those who have not contracted with the Networks are referred to in this Plan as “Non-Network Providers.” This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

- a. In the event a Network Provider refers a Participant to a non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.
 - b. The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
 - c. The Network Provider level of benefits is payable when the Participant requires Medically Necessary services or supplies, and there is no Network Provider available within 50 miles of the Participant's residence who is qualified to provide such services.
2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
 3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
 4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

14.02 Primary Care Providers

A current list of PPO providers is available, without charge, through the GWH – Cigna PPO Network website (located at www.mycignaforhealth.com). If you have any questions about how to do this, contact the Human Resources Department.

Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her 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. The PPO providers are merely independent contractors; neither the Plan nor the Plan Sponsor make any warranty as to the quality of care that may be rendered by any PPO provider.

14.03 Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Sponsor may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Sponsor has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Sponsor or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Sponsor has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

14.04 Calendar Year Maximum Benefit

The following calendar year maximums apply to each Participant:

Calendar Year Maximum Benefits for:	
2011: Essential Health Benefits	\$1 million
2012: Essential Health Benefits	\$1.25 million
2013: Essential Health Benefits	\$2 million
2014 and later: Essential Health Benefits	Unlimited
Lifetime Benefits	Unlimited
Outpatient Cardiac Rehabilitation	36 Visits
Chiropractic Care	60 Visits

14.05 Summary of Medical Benefits

The following benefits are per Participant per Plan Year:

	Network	Non-Network
Deductible ¹		
• Individual	\$250	\$500
• Family Unit ²	\$500	\$1,000
Coinsurance (unless otherwise stated)	Plan pays: 90% Patient pays: 10%	Plan pays: 70% Patient pays: 30%
Maximum Out-of-pocket ³		
• Individual	\$1,250	\$3,750
• Family Unit ⁴	\$2,500	\$7,500

¹ Any amount Participant previously accrued during the 2011 calendar year will be recognized and applied to the deductible requirement for the 2011 calendar year under this Plan.

² Family Unit Deductible will be satisfied when two family members each meet the \$250 Individual Deductible amount to total the required Family Unit Deductible of \$500. One family member alone cannot satisfy the Family Unit Deductible.

³ Includes Deductible amounts. Any amount Participant previously accrued during the 2011 calendar year will be recognized and applied to the out-of-pocket maximum under this Plan. After Participant's Out-of-Pocket Limit is reached, Plan will pay 100% until the end of the benefit period or the maximum benefit is reached.

⁵ Family Maximum Out-of-Pocket amount will be satisfied when two family members each meet the \$1,250 Individual Maximum Out-of-Pocket amount to total the required Family Maximum Out-of-Pocket amount of \$2,500. One family member alone cannot satisfy the Family Maximum Out-of-Pocket amount.

Covered Medical Expenses:	Network	Non-Network
1. Abortion Services ⁵	90% after Deductible	70% after Deductible
2. Allergy Services <ul style="list-style-type: none"> • Office Visit • Testing • Treatment & Serum 	90% after Deductible Not covered 90% after Deductible	70% after Deductible Not covered 70% after Deductible
3. Ambulance Services ⁶	90% after Deductible	70% after Deductible (if True Emergency covered at the Network rate)
4. Ambulatory Surgical Center	90% after Deductible	70% after Deductible
5. Anesthesia	90% after Deductible	70% after Deductible
6. Anesthesia for Dental Services ⁷	90% after Deductible	70% after Deductible
7. Birthing Center	90% after Deductible	70% after Deductible
8. Birth Control ⁸ <ul style="list-style-type: none"> • Office Visit • Office Procedures • IUD • Outpatient Facility Procedures 	90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible
9. Cardiac Rehabilitation ⁹	90% after Deductible	70% after Deductible
10. Chemotherapy	90% after Deductible	70% after Deductible
11. Chiropractic Care (limit 60 office visits per calendar year)	90% after Deductible	70% after Deductible
12. Dental Services ¹⁰	90% after Deductible	70% after Deductible
13. Diagnostic Lab & X-ray	90% after Deductible	70% after Deductible
14. Durable Medical Equipment ¹¹	90% after Deductible	70% after Deductible
15. Emergency Room	\$100 copay (waived if patient admitted)	\$100 copay (waived if patient admitted)
16. Hearing Aids (for children under age 18, starting January 1, 2012) ¹²	90% after Deductible	70% after Deductible

⁵ Abortion services are covered In-Network only in such instances when the mother's life is endangered due to the pregnancy or the pregnancy is the result of rape or incest.

⁶ Ambulance Services may include ground or air transportation only when such transportation is considered medically necessary by the average person.

⁷ Benefits will be available for anesthesia in connection with a dental procedure if such procedure involves: complex oral surgical procedures which have a high probability of complications due to the nature of the Surgery; concomitant systemic disease for which the patient is under current medical management and which increases the probability of complications; mental illness or behavioral condition which precludes dental Surgery in an office setting; use of general anesthesia, and the Participant's medical condition requires such procedure be performed in a Hospital; or dental Surgery performed on a Participant eight years of age or younger, where such procedure cannot safely be provided in a dental office setting.

⁸ Covered Birth Control Services include: Depo Provera injections; tubal ligation and vasectomy; insertion of IUD; surgical removal of IUD; and IUD equipment. Reversal of sterilization is not a covered service.

⁹ Coverage limited to 36 visits of cardiac rehabilitation per benefit period. Phases 1, 2, and 3 are covered.

¹⁰ Benefits are provided only for removal of impacted teeth or for dental work needed as a result of an Accidental Injury to the jaw, natural teeth, mouth, or face. An injury caused by chewing or biting, or received in the course of other dental procedures will not be considered an Accidental Injury.

¹¹ Must be approved in advance and purchased by an In-Network Provider. Includes replacement of equipment if necessary due to the Participant's growth and development. Routine maintenance and repair of equipment is not covered. Benefits are available to fit, adjust, repair, or replace Durable Medical Equipment due to normal wear or the Participant's physical development and not as a result of improved technology, loss, theft or damage.

17. Hearing Exams	Not covered	Not covered
18. Hemodialysis	90% after Deductible	70% after Deductible
19. Home Health Care (precertification required; limit 60 visits per calendar year)	90% after Deductible	70% after Deductible
20. Hospice Care (180 days per lifetime)	90% after Deductible	70% after Deductible
21. Hospital <ul style="list-style-type: none"> • Inpatient Treatment¹³ (precertification required) • Outpatient Surgery • Outpatient Routine, Non-Surgery 	90% after Deductible 90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible 70% after Deductible
22. Maternity Services ¹⁴	90% after Deductible	70% after Deductible
23. Medical and Surgical Supplies	90% after Deductible	70% after Deductible
24. Mental Health & Substance Abuse ¹⁵ <ul style="list-style-type: none"> • Inpatient (precertification required) • Outpatient Services 	90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible
25. Occupational Therapy, Outpatient (limit 20 visits per benefit period)	90% after Deductible	70% after Deductible
26. Orthotics (back, neck, knee, wrist, etc.) ¹⁶	90% after Deductible	70% after Deductible
27. Orthopedic Shoes and Foot Orthotics ¹⁷	90% after Deductible	70% after Deductible
28. Physical Therapy, Outpatient (limit 20 visits per benefit period)	90% after Deductible	70% after Deductible
29. Physician Office Visits for Non-Routine Care	90% after Deductible	70% after Deductible
30. Physician Visits During Inpatient Hospital/SNF Confinement	90% after Deductible	70% after Deductible
31. Podiatry Services ¹⁸	90% after Deductible	70% after Deductible
32. Prosthetic Appliances ¹⁹	90% after Deductible	70% after Deductible
33. Radiation Therapy	90% after Deductible	70% after Deductible
34. Respiratory Therapy, Outpatient	90% after Deductible	70% after Deductible
35. Routine Health Maintenance ²⁰ (age 6 and older)	90% after Deductible	Not covered

¹² Hearing Aids will be covered every three years for children under 18 years old up to \$1,000 per hearing aid per ear.

¹³ Private room is covered up to the semi-private room rate. In a private room only hospital, private room is covered at the billed private room rate. Medically Necessary private rooms are covered at the billed private room rate.

¹⁴ All female participants are covered. Limit 2 ultrasounds per uncomplicated pregnancy. No limitations on ultrasounds for complicated pregnancy. Medically Necessary amniocentesis is covered. Midwife services are not covered. Natural birthing classes (Lamaze) are not covered.

¹⁵ Covered services include: Autism, ADD/ADHD, mental health, substance abuse and chemical dependency evaluation and assessment, diagnosis, treatment planning, referral services, short term individual, family, and group therapeutic services, and crisis intervention.

¹⁶ Routine maintenance is covered. Replacement covered if necessary due to the Participant's growth and development. Repairs are not covered.

¹⁷ Orthopedic Shoes and Foot Orthotics are covered only if Medically Necessary, prescribed by a Network Physician, approved in advance, and purchased by a Durable Medical Equipment Provider.

¹⁸ Palliative services are not covered. Covered services include: capsular or bone surgery for treatment of bunions; complete or partial removal of the nail matrix affected by disease, infection or fungus; surgical procedures or injections involving the bones, nerves, muscles or tendons of the foot or ankle; and cutting or removal of corns, calluses or toenails if done in connection with an underlying medical condition such as diabetes or peripheral vascular disease.

¹⁹ Routine maintenance is covered. Replacement is covered if necessary due to the Participant's growth and development. Dental and penile prosthesis are not covered. Repairs are not covered.

36. Routine Well Baby & Child Care ²¹ (birth to age 2)	90% after Deductible	Not covered
37. Routine Well Child Care (age 2 to age 6)	90% after Deductible	Not covered
38. Second and Third Surgical Opinions	90% after Deductible	70% after Deductible
39. Skilled Nursing Facility (precertification required; limit 60 days per benefit period)	90% after Deductible	70% after Deductible
40. Sleep Disorders	90% after Deductible	70% after Deductible
41. Speech Therapy, Outpatient (limit 20 visits per benefit period)	90% after Deductible	70% after Deductible
42. Surgeon	90% after Deductible	70% after Deductible
43. Temporomandibular Joint Disorder (TMJ)	90% after Deductible	70% after Deductible
44. Transplants ²²	90% after Deductible	70% after Deductible
45. Urgent Care Facility	90% after Deductible	70% after Deductible
46. Vision Services ²³ <ul style="list-style-type: none"> • In connection with a medical condition • Eyeglasses or Contact Lenses (one set following Cataract surgery) 	90% after Deductible 90% after Deductible	70% after Deductible 70% after Deductible

14.06 Summary of Prescription Drug Benefits

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy
Pharmacy Option:	
Per prescription or refill, for generic	90% after Deductible
Per prescription or refill, for formulary name brands ^[24]	90% after Deductible
Per prescription or refill, for non-formulary name brands	90% after Deductible
Mail Order Option²⁵:	
Per prescription or refill, for generic	90% after Deductible
Per prescription or refill, for formulary name brands ^[26]	90% after Deductible
Per prescription or refill, for non-formulary name brands	90% after Deductible
Maximum Benefits:	
All prescription drugs, per drug, up to a 30-day supply	\$12,000 per prescription
All prescription drugs, per drug, between a 31-day and 90-day supply	\$24,000 per prescription

²⁰ Includes: 1 routine physical exam per benefit period; 1 routine OB/GYN exam per benefit period, not combined with physical exam; routine mammogram (no age limit); routine pap smear; routine lab and pathology; routine bone density; routine prostate exam; flu shot; flu mist (ages 25 months to 49 years); routine immunizations; Gardasil immunization; HPV testing; routine colonoscopy; routine sigmoidoscopy; and Shingles vaccination (age 60 and over).

²¹ Includes: routine exams; routine immunizations; routine lab and pathology.

²² Services must be provided by a Center of Excellence. Failure to use a Center of Excellence will result in no coverage. Covered transplants include: bone marrow (allogeneic or autologous), cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung (single), pancreas, prosthetic lenses (implantable in connection with cataracts), prosthetic bypass or replacement vessels, stem cell transfer, small bowel and small bowel/liver. Transportation, meals and lodging in connection with transplant are covered up to a maximum of \$10,000 per covered transplant. Procurement is covered without limitation. Donor expenses are not covered.

²³ Annual eye exams are not covered.

²⁴ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.

²⁵ Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

ARTICLE XV MEDICAL BENEFITS

15.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise;
2. **Allergy Services.** Charges related to the Treatment of allergies;
3. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement;
4. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
5. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
6. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
7. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
8. **Cardiac Rehabilitation Therapy.** Phase I and Phase II Cardiac Rehabilitation Programs in connection with the rehabilitation of the Covered Person following a myocardial infarction or coronary occlusion or coronary bypass Surgery when such rehabilitation services are rendered under the supervision of a Physician in a Facility.
9. **Chemotherapy.** Charges for chemotherapy/radiation;
10. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;
11. **Dental.** Emergency repair due to Injury to sound natural teeth;
12. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;
13. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. Replacements will be covered if necessary due to the Participant's growth and development. The Plan does not pay for:
 - a. Any purchases without its advance approval;
 - b. Unnecessary replacements or routine maintenance and repairs; or
 - c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment";
14. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);

15. **Glaucoma.** Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);

16. **Gleevec.** Gleevec, for treatment of any of the following conditions:

- a. CML myeloid blast crisis;
- b. CML accelerated phase; or
- c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan;

17. **Hearing Aids.** Charges for any wearable, nonexperimental, nondisposable instrument or device designed for the ear and used to aid or compensate for impaired human hearing, including earmolds and services necessary to select, fit, and adjust the hearing aid, but excluding batteries, cords, and other assistive listening devices such as FM systems;

18. **Home Health Care.** Charges by a Home Health Care Agency:

- a. Registered Nurses or Licensed Practical Nurses;
- b. Certified home health aides under the direct supervision of a Registered Nurse;
- c. Registered therapist performing physical, occupational or Speech Therapy;
- d. Physician calls in the office, home, clinic or Outpatient department;
- e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
- f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

NOTE: Transportation services are not covered under this benefit;

19. **Hospice Care.** Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

- a. Room and Board for Confinement in a Hospice;
- b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
- c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
- d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
- e. Home health aide services;
- f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
- g. Medical social services by licensed or trained social workers, Psychologists or counselors;
- h. Nutrition services provided by a licensed dietitian;
- i. Respite care; and
- j. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased's Family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death. Benefits will be payable up to 180 days per lifetime if the following requirements are met:

- (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Plan Participant under the Plan; and

- (2) Charges for such services are Incurred by the Plan Participants within 6 months of the Terminally Ill person's death.

The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal illness enters remission;

20. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

- (1) Daily Semi-Private Room and Board charges;
- (2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
- (3) General nursing services; and
- (4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

b. Outpatient Treatment

- (1) Emergency room;
- (2) Treatment for chronic conditions;
- (3) Physical Therapy treatments;
- (4) Hemodialysis; and
- (5) X-ray, laboratory and linear therapy;

21. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment limited to: artificial insemination and in-vitro fertilization. Treatments not covered include: Drug Therapy, Gamete (GIFT) and Zygote (ZIFT) and intra fallopian transfer procedure;

22. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

- a. Reconstruction of the breast on which the Mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

23. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

24. **Newborn Care.** Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Charges for Newborn Care of a dependent child's newborn will not be covered. If the Newborn's hospital and nursery care extends past the time the mother is discharged from the hospital, benefits will be provided under the child's coverage, and the child's own Deductible and coinsurance provisions will apply:

- a. Hospital routine care for a Newborn during the child's initial Hospital Confinement at birth; and

- b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
 - (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
 - (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

- 25. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
- 26. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;
- 27. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;
- 28. **Orthopedic Shoes.** Charges for Orthopedic Shoes are covered only if Medically Necessary, prescribed by a Network Physician, approved in advance, and purchased by a Durable Medical Equipment Provider;
- 29. **Pathology Services.** Charges for Pathology Services;
- 30. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;
- 31. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;
- 32. **Pregnancy Expenses.** Dependent Children are eligible for coverage for any expenses in connection with Pregnancy. Coverage may be available for expenses related to certain complications of Pregnancy. Charges for Newborn Care of a dependent child's newborn will not be covered.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the "Summary of Benefits" and this section, and subject to the same maximums;

- 33. **Prescription Contraceptives.** The Plan will also cover contraception-related services, including the initial visit to the prescribing Physician and any follow-up visits or Outpatient services, to the same extent, and on the same terms, as it offers coverage for other Outpatient services for preventative care;
- 34. **Preventive Care.** Charges for preventative care services;

35. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, including Foot Orthotics and orthopedic shoes when attached to a brace;
36. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;
37. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
38. **Second Surgical Opinions.** Charges for second surgical opinions;
39. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;
40. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;
41. **Sterilization.** Charges related to sterilization procedures;
42. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 - a. Multiple procedures adding significant time or complexity will be allowed at:
 - (1) 100% of the full Usual and Customary Fee value for the first or major procedure;
 - (2) 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;
 - b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;
 - c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual and Customary Fee value for the type of surgery performed;
 - d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
43. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;
44. **Temporomandibular Joint Disorder.** Charges for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment. **If a Physician or Dentist recommends treatment for or in connection with temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment, a Participant must submit the treatment plan, including x-rays and study models, for pre-determination of benefits under the Plan. The pre-determination of benefits is required before any course of treatment is begun.** The Plan Sponsor will determine if the treatment is a Covered Expense and will notify the Participant. If treatment is begun before the pre-determination of benefits, no benefits are payable under the Plan; and

45. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

- a. Bone marrow;
- b. Heart;
- c. Lung;
- d. Heart and lung;
- e. Liver;
- f. Pancreas;
- g. Kidney;
- h. Cornea; and
- i. Small bowel

In addition, the Plan will cover any other transplant that is not Experimental.

Covered expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a Provider; and
- c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

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

15.02 Psychiatric and Substance Abuse Benefits

15.02A Inpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board;
2. Miscellaneous facility charges on days a Room and Board charge is covered;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Family counseling; and
7. Convulsive therapy treatment.

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

15.02B Outpatient Benefits

Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling;
5. Convulsive therapy treatment; and
6. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

15.03 Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in Article VII, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Acupuncture.** Charges relating directly or indirectly to acupuncture, acupressure, hypnotism, rolfing, massage therapy, aroma therapy, and other forms of alternative treatment;
2. **Allergy Testing.** Charges related to Allergy Testing;
3. **Amniocentesis.** Health services and associated expenses for unnecessary amniocentesis;
4. **Biofeedback.** Biofeedback;
5. **Consultations.** Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
6. **Cosmetic Surgery.** Health services and associated expenses for cosmetic procedures including, but not limited to, pharmacological regimens; nutritional procedures or treatments; plastic surgery; salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne; radial keratotomy and other refractive eye surgery. (Cosmetic procedures are those procedures which improve physical appearance. Reconstructive Surgery is surgery which is incidental to an Injury, Sickness or congenital anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.) Breast reconstruction following mastectomy for cancer is covered;
7. **Custodial Care.** Custodial Care, domiciliary care, private duty nursing or rest cures, or home health care except as specifically provided herein. (Custodial Care means: (1) non-health related services, such as assistance in activities of daily living, or (2) health-related services which do not seek to cure or which are provided during periods when the medical condition of the patient is not changing; or (3) services which do not require continued administration by trained medical personnel.);
8. **Dental Services.** Dental Services provided by a Doctor of Dental Surgery, D.D.S., or Doctor of Medical Dentistry, "D.M.D.", or by a Physician licensed to perform dental services. Excluded services include dental implants, services for overbite or underbite. Dental x-rays, supplies and appliances (including occlusal splints) and all associated expenses arising out of such dental services including hospitalizations and anesthesia, except as might otherwise be required for direct treatment of acute traumatic Injury or cancer;
9. **Durable Medical Equipment and Prosthetics.** Repair or replacement for any otherwise covered prosthetic or Durable Medical Equipment except when necessitated due to a change in the Covered Person's medical condition or to improve physical function.
10. **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 education or training program, except as specifically provided herein;
11. **Fittings.** Charges incurred in connection with the provision or fitting of hearing aids, eye glasses, or contact lenses.

12. **Growth Hormone Therapy.** Growth Hormone Therapy except as may be provided as a prescription drug benefit for a documented growth hormone deficiency, Turner's Syndrome, growth delay due to cranial radiation, or chronic renal disease;
13. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness;
14. **Hearing Devices.** Hearing aids or examinations for the prescription or fitting of hearing aids;
15. **Hypnosis.** Expenses related to the use of hypnosis;
16. **Implant.** Repair or replacement for any otherwise covered implant. Penile implants for the treatment of impotence having a psychological origin;
17. **Megavitamin Therapy.** Health services and associated expenses for megavitamin therapy;
18. **Military Service-Related Disabilities.** Health services for treatment of military service-related disabilities, when the Covered Person is legally entitled to other coverage and facilities are reasonably available to the Covered Person;
19. **Nutritional-Based Therapy.** Health services and associated expenses for nutritional-based therapy. Enteral feedings and other nutritional and electrolyte supplements;
20. **Obesity.** Health services and associated expenses for the surgical treatment and non-surgical, medical treatment of obesity (including morbid obesity);
21. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;
22. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;
23. **Personal Convenience Items.** Items or services that do not meet the definition of Durable Medical Equipment, including air conditioners, barber or beauty service, guest service, humidifiers, exercise equipment, television, telephone, and other similar incidental services and supplies whether or not recommended by a Physician;
24. **Pre-existing Condition.** Pre-existing Conditions, except as specifically provided in the section entitled "Special Restrictions for Pre-Existing Conditions";
25. **Psychosurgery.** Health services and associated expenses for psychosurgery;
26. **Purposes Not Covered.** Physical, psychiatric or psychological examinations, testing, vaccinations, immunizations or treatments not otherwise covered under the Plan, when such services are: (1) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (2) relating to judicial or administrative proceedings or orders; (3) conducted for purposes of medical research; or (4) to obtain or maintain a license of any time;
27. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;
28. **Routine Physical Examinations.** Routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits;

29. **Safety Items.** Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation;
30. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic disease;
31. **Sterilization.** Health services and associated expenses for the reversal of voluntary sterilizations;
32. **Surrogate Parenting.** Health services and associated expenses for surrogate parenting;
33. **Terminated Coverage.** Health services otherwise covered under the Plan, but rendered after the date individual coverage under the Plan terminates, including health services for medical conditions arising prior to the date individual coverage under the Plan terminates.
34. **Travel.** Travel or transportation expenses, whether or not recommended by a Physician, except as specifically provided herein; and
35. **Vitamins.** Vitamins.

15.04 Cost Containment

15.04A Pre-Certification Procedures

The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant's responsibility to call the pre-certification department at its toll-free number, which is 1-800-262-4772. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. **Pre-certification is required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.**

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Non-emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

The pre-certification department hours of operations are Monday through Friday 8:00am through 5:00pm. On weekends and evenings, the Participant can call 1-800-262-4772, and leave a message.

15.04B Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department of any Inpatient Hospital stay as required in the section entitled "Pre-Certification Procedures," allowed charges will not be covered for Room and Board, Hospital miscellaneous services, and any other charges related to that confinement which are billed by the Hospital. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

15.04C Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Sponsor should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

15.04E Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan **recommends** that a second opinion be obtained **prior to** the following Surgeries:

1. Adenoidectomy;
2. Bunionectomy;
3. Cataract removal;
4. Coronary Bypass;
5. Cholecystectomy (removal of gallbladder);
6. Dilation and curettage;
7. Hammer Toe repair;
8. Hemorrhoidectomy;
9. Herniography;
10. Hysterectomy;
11. Laminectomy (removal of spinal disc);
12. Mastectomy;
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
14. Nasal Surgery (repair of deviated nasal septum, bone or cartilage);
15. Prostatectomy (removal of all or part of prostate);

16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
17. Tonsillectomy; and
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of Usual and Customary Fees incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

15.04F Pre-Surgical Approval

The Plan **requires** that a pre-determination of benefits be obtained **prior to** all Surgical procedures to determine Medical Necessity.

**ARTICLE XVI
PRESCRIPTION DRUG BENEFITS**

Covered Prescription Drug Expenses:	Participating Pharmacy ²⁶
Pharmacy Option:	
Per prescription or refill, for generic	90% after Deductible
Per prescription or refill, for formulary name brands ^[27]	90% after Deductible
Per prescription or refill, for non-formulary name brands	90% after Deductible
Mail Order Option²⁸:	
Per prescription or refill, for generic	90% after Deductible
Per prescription or refill, for formulary name brands ^[29]	90% after Deductible
Per prescription or refill, for non-formulary name brands	90% after Deductible
Maximum Benefits:	
All prescription drugs, per drug, up to a 30-day supply	\$12,000 per prescription
All prescription drugs, per drug, between a 31-day and 90-day supply	\$24,000 per prescription

Participating pharmacies (“Participating Pharmacies”) have contracted with the Plan to charge Participants reduced fees for covered Drugs. EnvisionRxOptions is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. **No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.**

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, Orchard Mail Order Pharmacy, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

16.01 Covered Expenses

The following are covered under the Plan:

1. **Acne Control.** Charges for acne control;
2. **Administration.** Any charge for the administration of a covered Drug;
3. **Allergy Sera.** Charges for allergy sera;
4. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;

²⁶ 100% payment by Plan after the calendar year Out-of-Pocket maximum is reached.

²⁷ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated “dispense as written” or similar indication.

²⁸ Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

5. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;
6. **DESI Drugs.** Charges for DESI Drugs;
7. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;
8. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over-the-counter, and glucose test strips, when prescribed by a Physician;
9. **Gleevec.** Gleevec, for treatment of any of the following conditions:
 - a. CML myeloid blast crisis;
 - b. CML accelerated phase; or
 - c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan.

10. **Growth Hormones.** Charges for growth hormones;
11. **Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector);
12. **Immunizations.** Immunization agents or biological sera;
13. **Immunologicals.** Charges for Immunosuppressants;
14. **Impotency.** A charge for impotency medication, including Viagra™;
15. **Injectables.** A charge for injectables;
16. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;
17. **Legend Drugs.**
 - a. Class V Drugs;
 - b. Legend Drugs with Over-the-Counter equivalent; and
 - c. Pre-natal vitamins;
18. **Oral Contraceptives.** Charges for oral contraceptives;
19. **Over-the-Counter Drugs.** The following Over-the-Counter drugs are covered at \$0 copay:
 - a. Prilosec OTC, Prevacid-24, Zegerid OTC and any generic and trade alternatives to Prilosec OTC, Prevacid-24, and Zegerid OTC;
 - b. Claritin, Claritin-D, and any generic and trade alternatives to Claritin and Claritin-D;
 - c. Abreva and the generic and any generic and trade alternatives to Abreva;
 - d. Zaditor and the generic and any generic and trade alternatives to Zaditor;
 - e. Zyrtec, Zyrtec-D, and any generic and trade alternatives to Zyrtec and Zyrtec-D;
 - f. Slo-Niacin Oral Tablet Extended Release, and any generic and trade alternatives to Slo-Niacin;
 - g. Allegra Allergy and Allegra D Allergy and Congestion and any generic and trade alternatives to

Allegra Allergy and Allegra D Allergy and Congestion.

20. **Pre-Natal Vitamins;**

21. **Prescription Contraceptives.** The Plan will cover each of the available options for prescription contraception to the same extent, and on the same terms, that it covers other drugs, devices, and preventative care services; and

22. **Smoking Deterrents.** A charge for Zyban or Chantix;

23. **Steroids.** Anabolic steroids; and

24. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

16.02 Limitations

The benefits set forth in this Article will be limited to:

1. **Dosages.**

- a. With respect to the Pharmacy Option, any one prescription is limited to the greater of a 30-day supply or a 360 tab/150 gram/4000 ml-unit dose; and
- b. With respect to the Mail Order Option, any one prescription is limited to the greater of a 90-day supply or a 1080 tab/450 gram/12000 ml-unit dose; and

2. **Refills.**

- a. Refills only up to the number of times specified by a Physician; and
- b. Refills up to one year from the date of order by a Physician.

3. **Maximum Benefit.**

- a. With respect to all prescription drugs:
 - (1) A maximum of \$12,000 per prescription applies to each drug, up to a 30 day supply.
 - (2) A maximum of \$24,000 per prescription applies to each drug, between a 31-day and a 90-day supply.

16.03 Exclusions

In addition to the General Exclusions set forth in Article VII, the following are not covered by the Plan:

1. **Anorexiant.** Anorexiant (weight-loss drugs);

2. **Bee Sting Kits.** Charges for EPIPEN and Ana-Kit;

3. **Blood and Blood Plasma.** Charges for Blood and Blood Plasma;

4. **Excluded Items.** Any charge excluded under the Articles entitled “General Limitations and Exclusions,” or “Summary of Benefits”;

5. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;

6. **Fertility Agents.** Charges for fertility agents;

7. **Investigational Use Drugs.** A Drug or medicine labeled “Caution – limited by Federal law to investigational use;”

8. **Medical Devices and Supplies.** Charges for legend and over-the-counter medical devices and supplies;

9. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;
10. **Non-Insulin Syringes/Needles.** Charges for non-insulin syringes and needles;
11. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin and the covered Over-the-Counter Drugs listed in 18.01(19);
12. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;
13. **Rogaine.** Charges for Rogaine (topical minoxidil);
14. **Vitamins.** Vitamins, except pre-natal vitamins.

ARTICLE XVII HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI;
2. The Plan Participant’s privacy rights with respect to his/her PHI;
3. The Plan’s duties with respect to his/her PHI;
4. The Plan Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual’s express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Sponsor will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

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

The Plan Sponsor may hereby authorize and direct 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.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. **Treatment, Payment and Health Care Operations:** The Plan has the right to use and disclose a Plan Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant’s information.
3. **Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. **Required by Law:** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. **Public Health and Safety:** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
 - (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; and
 - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant’s agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will

promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. **Health Oversight Activities:** The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. **Lawsuits and Disputes:** The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.
6. **Law Enforcement:** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. **Decedents:** The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.
8. **Research:** The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. **To Avert a Serious Threat to Health or Safety:** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. **Workers' Compensation:** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. **Military and National Security:** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. **Disclosures to Plan Participants:** The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal

representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.
3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.
5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.
6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Compliance Coordinator Contact Information:

Director of Human Resources
City of Murfreesboro
111 West Vine Street
Murfreesboro, TN 37133
615-848-2553

ARTICLE XVIII HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

“Electronic Protected Health Information” (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“Security Incidents” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.