**PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION FOR:**

**Grandfathered Plan**

# CITY OF KINGSVILLE
# HEALTH BENEFIT PLAN

**Amended & Restated October 1, 2012**

**Claims Administered by:**

ENTRUST®
INSURANCE AND BENEFIT PROFESSIONALS

***You are required to call (877) 463-3435 for hospital Pre-authorization. Refer to Medical Management section for details.***

**Please see Medicare Part D section for important rights you may have regarding Medicare prescription coverage.**

*This document reflects the medical benefits included under your employee benefit plan. If Life and AD&D coverage is also included, each covered employee will receive a separate Life and AD&D Summary Plan Description.*

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# INTRODUCTION

This document is a description of the City of Kingsville Employee Benefit Plan Trust (the Plan) sponsored by the Employer shown in Appendix A. The Plan described is designed to protect Plan Participants against catastrophic health expenses where covered and not specifically excluded.

**Grandfathered Health Plan Status.**

The Plan believes it 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 your Employer or Entrust, Inc., Claims Administrator, at 1-800-436-8787. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

When a person is employed, that person's salary pays the expenses of day-to-day living. If an illness or injury occurs, the cost involved could cause financial difficulties. This Plan can ease such financial burdens by providing reimbursement for covered expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the waiting period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Any amendments to the Plan will be implemented on the first of the month following the date the amendment is approved and signed by the Plan Administrator.

If the Plan is terminated, the rights of Plan Participants are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Eligibility, Enrollment, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Qualified Medical Child Support Orders (QMCSOs).** Explains the administrative process under state law wherein certain circumstances require health coverage for a participant's child.

**Medical Benefits.** Explains when the benefit applies and the types of charges covered.

**Plan Exclusions and Limitations.** Shows what charges are **not** covered or may have benefit limitations.

**Prescription Drug Benefits.** Explains when the benefit applies and the types of charges covered.

**Ask-A-Nurse / Medical Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**Claim Procedures.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment orders when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the **Plan's** rights to recover payment of charges when a Plan Participant has a claim against another person because of injuries sustained.

**Responsibilities for Plan Administration.** Outlines the duties of the employer plan sponsor, plan administrator and fiduciaries.

**Special Provisions.** Explains the **Plan's** structure and the Participants' rights under the Plan.

**Important Notices of Participants Rights**. Explains certain Participants rights under federal statutes such as COBRA, HIPAA and Medicare Part D.

**This Document should be read carefully since it contains important information about the benefits provided by your plan.**

***For any Plan Participant (including spouse and dependents), a copy of this Document is available upon written request.***

# DEFINED TERMS

The following terms have special meanings when used in this Plan.

Subject to Plan exclusions and limitations, the **Allowable Amount** for **Network Providers** means the amount eligible for payment consideration which is the lesser of the actual charge, the discounted charge, an agreed negotiated amount between the parties, the prevailing charge or the charge the Plan Administrator deems Reasonable and Necessary for the Plan.

Subject to Plan exclusions and limitations, the **Allowable Amount** for non-negotiated **Non-Network Providers** will be as follows:

- **For procedures, services or supplies provided by non-network physicians and other providers** (including Hospital Emergency Room Physician Services)– allowable charges shall be the lesser of 125% of the Resource Based Relative Value Scale (RBRVS) schedule as used by CMS (Centers for Medicare & Medicaid Services) or the actual billed charges.
- **For procedures, services or supplies provided by non-network anesthesiologists** – allowable charges shall be the lesser of five (5x) times the Resource Based Relative Value Scale (RBRVS) schedule as used by CMS (Centers for Medicare & Medicaid Services) or the actual billed charges.
- **For procedures, services or supplies provided by non-network Ambulatory Surgical Center Facilities** – allowable charges shall be the lesser of 125% of the Resource Based Relative Value Scale (RBRVS) schedule as used by CMS (Centers for Medicare & Medicaid Services) or the actual billed charges.
- **For non-negotiated in-patient Hospitals** – allowable charges shall be the lesser of $4000 per diem (all-inclusive) for Medical and Surgical charges or the actual billed charges.
- **For non-negotiated in-patient Hospital Charges for Intensive Care Unit** – allowable charges shall be the lesser of $5000 per diem (all-inclusive) for Intensive Care Unit charges or actual billed charges.
- **For all other non-network Outpatient or Other services (including Skilled Nursing Facility or Emergency Services in an Emergency Department of a Hospital)** – allowable charges shall be limited to 60% of the billed charges unless a different amount is specified in the Schedule of Benefits.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Approved Leave of Absence** means any absence by an Employee who is on a family and/or medical leave of absence or any other leave approved by the Employer under its usual policies. An approved leave of absence will run concurrently with leave under the Family Medical Leave Act unless specified in writing from the Employer that it will be treated differently.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse mid-wife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require post-delivery confinement.

**Calendar Year** means January 1st through December 31st of the same year.

**Chiropractic Care/Spinal Manipulation** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Claims Administrator** means Entrust, Inc.

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

**Coinsurance** means a Covered Person's share of the cost of covered services and supplies, not counting the Deductible or co-payments. Coinsurance is usually expressed as a percentage of the allowable amount. For example, if the Coinsurance amount is "80/20" that means that the primary carrier pays 80% and the Plan Participant pays 20% of the allowable amount for the eligible charges.

**Complications of Pregnancy** is a condition or conditions with a diagnosis distinct from pregnancy but which may be caused by or adversely affected by pregnancy. Complications include but are not limited to:

(1) Nephritis, neophrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and

(2) Cesarean section, termination of ectopic pregnancy and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

**Convenience Care Clinic** means the healthcare clinics located in retail stores, supermarkets and pharmacies that treat routine family illness on a limited basis and provide certain preventative heathcare services, such as flu shots.

**Co-Payment** is a fixed amount paid by the plan participant for covered services at the time they are rendered or for covered prescription medications.

**Cosmetic Dentistry** means unnecessary dental surgical procedures, usually but not limited to, plastic surgery directed toward enhancing dental attractiveness.

**Cosmetic Surgery** means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurement.

**Covered Person** is an Employee or Dependent who is covered under the Plan.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Emergency Services** means, with respect to an Emergency Medical Condition, treatment or services for an Injury or Illness that is of serious, life-threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment that is within the capability of the emergency department of a Hospital to evaluate such Emergency Medical Condition and to stabilize the patient.

**Emergency Medical Condition** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions placing the health of the individual (or unborn child) in serious jeopardy.

**Employee** means a person who is a Full-Time Employee of the Employer, regularly scheduled to work for the Employer in an Employee-Employer relationship.

**Employer** is City of Kingsville. ("City of Kingsville").

**End Stage Renal Disease (ESRD)** means permanent kidney failure, requiring dialysis and/or an anticipated kidney transplant, entitling the Plan Participant or covered Dependent to Medicare coverage as established by the Balanced Budget Act of 1997.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigational** means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible,

relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

(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; or

(2) If the drug, device, treatment, or any combination thereof, is not FDA approved, whether it meets the National Comprehensive Cancer Network Guidelines for treatment; or

(3) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(4) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(5) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**Foster Child** means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Full-Time Employee** means an Employee who normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

**Full-Time Employment** means working at least 30 hours per week and being on the regular payroll of the Employer for that work.

**Generic Drug** means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any generic pharmaceutical, which is approved by the Food and Drug Administration ("FDA") and is dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic. However, a Prescription Drug will not be considered as generic unless it has been categorized by the FDA as generic for more than one year.

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

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996.

**Home Health Care Agency** is an organization that meets all of these test: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two (2) unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hours-a-day nursing services by or under the supervision of registered nurses(R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "**Hospital**" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a condition, sickness or disease not resulting from trauma.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** is a Plan Participant who enrolls under the Plan other than during a Special Enrollment Period or during the initial 31-day period in which the Plan Participant first became eligible to enroll under the Plan.

**Legal Guardian** is a person recognized by a court of law with the duty of taking care of and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

**Medical Care Facility** means a Hospital or other facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. The fact that a physician may prescribe, order, recommend or approve of a service or supply does not, by itself, make it **Medically Necessary** or make the charge an allowable expense, even though it is not specifically listed as an exclusion.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
**Network** means the Preferred Provider Organization (PPO) network of providers offering discounted fees for services and supplies to Covered Persons under the primary carrier plan.

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

**Occupational Therapy** is treatment of a physically disabled Plan Participant by means of constructive activities designed and adapted to promote the restoration of the person's ability to accomplish satisfactorily the ordinary tasks of daily living and those required by the person's particular occupation.

**Open Enrollment Period** will occur during the 30 days before the end of the current Plan year.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a Pharmacist licensed under the laws of the state where he or she practices.

**Physician** means 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.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Licenses Professional Surgical Assistant, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and/or certified and regulated by a state or federal agency and is acting within the scope of his or her license and/or certification.

**Plan** means the City of Kingsville Employee Benefit Plan Trust, which is a benefits plan for employees of the Employer.
**Plan Administrator** is an individual or group of individuals usually named in the plan document responsible for plan duties.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Plan Sponsor** means City of Kingsville.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis; care or treatment was recommended or received within six (6) months of a person's Enrollment Date. For these purposes, Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnosis tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition Exclusion does not apply to Pregnancy and to certain children. See the section of the Plan entitled "Pre-Existing Conditions."

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be **Medically Necessary** in the treatment of a Sickness or Injury.

**Reasonable and Necessary Fees (R&N)** means services and supplies which are medically necessary for the care and treatment of illness or injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

- The fee which the provider charges the patients for the service or supply;
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply; and/or
- The Allowable Amount as defined by the Plan.

**Retired Employee/Retiree** is a former Full-Time Employee of the Employer who was retired while employed by the Employer under their formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

**Sickness** is a person's illness, disease or Pregnancy (including complications).

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered

nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

The term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulations or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Surgical Procedure (or Surgery)** is any of the following:

- the incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of wounds;
- the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of a cast or traction;
- 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;
- arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- obstetrical delivery and dilation and curettage;
- biopsy.

**Temporomandibular Joint (TMJ) Syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Urgent Care.** A sudden, acute and unexpected medical condition that requires timely diagnosis and treatment but does not pose an immediate threat to life or limb. Examples of Urgent Care include, but are not limited to: colds and flu, sprains, stomach aches and nausea. Urgent Care may be accessed

from an Urgent Care Clinic if the Plan Participant requires non-Emergency medical care or Urgent Care after the normal business hours of the Plan Participant's Physician.

**Urgent Care Clinic**. A clinic with extended office hours that provides Urgent Care and minor Emergency care to patients on an unscheduled basis without need for an appointment. The Urgent Care Clinic does not provide routine follow-up care or wellness examinations and refers patients back to their regular physician for such routine follow-up and wellness care.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act.

# SCHEDULE OF BENEFITS

## PLAN A

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **Family Monthly Deductible**<br>Per Family Unit<br>*(co-payments do not apply)* | $200 | Not Covered |
| **Coinsurance** | 100% | Not Covered |
| **Maximum Out-of-Pocket Coinsurance**<br>*(excludes deductibles and co-payments)* | $0 | Not Covered |
| **THE MONTHLY DEDUCTIBLE WILL BE WAIVED FOR ALL SERVICES WITH A CO-PAYMENT, UNLESS OTHERWISE SPECIFIED.** | | |
| **Annual Maximum Amount** | $2,000,000 | |
| **Lifetime Maximum Amount**<br>*All Medical Benefits* | Unlimited | |
| ***Note:*** *For Medically Necessary Services rendered by a Network Provider, the benefits of this Plan will be provided after the deductible has been met until the out-of-pocket amounts are reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Allowable Amount for the remainder of the Calendar Year for all covered medical expenses, unless otherwise specified. Any balances of charges not covered by this Plan will be your responsibility to pay. The deductible and co-payments do not accrue towards the maximum out-of-pocket expense.* | | |
| **Covered Services** | **Network Providers** | **Non-Network Providers** |
| **The Allowable Amount for Network Providers is the contracted discounted amount.** | | |
| **Physicians Office Visit**<br>Includes all related services performed plus allergy testing, treatment, x-rays, laboratory and in-office surgery<br>*Charges must be on same bill and incurred on the same day of service* | $15 Co-pay then covered at 100% up to a maximum of $200 per visit, then 100% after deductible. | Not Covered |
| **Routine Preventative Care**<br>Includes routine annual physical examinations, prostate exams, colon cancer screenings, gynecological exam, pap smear, mammogram, x-rays, laboratory, and immunizations after age 6 | $15 Co-pay, then covered at 100% up to a $300 maximum per Calendar year | Not Covered |
| **Immunizations to age 6** | Covered at 100% | |
| **Outpatient Diagnostic Testing, Laboratory and/or Radiology**<br>-Hospital and Freestanding Facility<br>(Excludes Emergency Room)<br>(Includes CT Scan, MRI, and PET Scan) | $15 Co-pay then covered at 100% up to a maximum of $150 per visit, then covered at 100% after deductible | Not Covered |

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount.** | | |
| **Maternity Care**<br>Covered Employee & Spouse | Benefits are the same as those stated under each Covered Services category | Not Covered |
| **Hospital Service – Inpatient/Outpatient**<br>Daily Room and Board limited to the charges up to the semi-private room rate.<br>Intensive Care Unit limited to Hospital's ICU charge | Covered at 100% after deductible | Not Covered |
| **Skilled Nursing Facility - Inpatient Services**<br>Covered at the lesser of the following:<br>(a) The daily charge of the regular daily charge for a semi-private room in the Hospital from which the patientwas discharged or (b) $350 per diem<br>Limited to 100 days per Calendar Year | Covered at 100% after deductible | Not Covered |
| **Hospital Confinement for Rehabilitation**<br>*Note: Covered maximum daily allowable amount of $850 subject to pre-authorization and/or case management.* | Covered at 100% after deductible | Not Covered |
| *Covered services provided by a Non-Network radiologist, anesthesiologist, pathologist or other Physician over whom the Plan Participant had no control in selecting while receiving care (Inpatient/Outpatient) from a Network Hospital will be payable at the Network level of benefits.* | | |

**PRE-AUTHORIZATION/UTILIZATION REVIEW**

**Only the following services must be pre-authorized:**

**Inpatient hospital confinements**

**Pre-authorization is not required for Inpatient maternity confinements within the minimum stay requirements.**

**Proper Authorization must be obtained in a timely manner**

**It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Pre-authorization/Utilization Review requirements.**

**Please see the Medical Management section of this booklet for details.**

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount.** | | |
| **Emergency Room**<br>**Hospital & Physician Services**<br>Medical Emergency/Accidental Injury<br>(co-pay waived if admitted as inpatient) | $75 Co-pay, then covered at 100% up to a maximum of $300 per visit, then 100% after deductible | Not Covered |
| ***Note:*** *Non-Network Emergency Services rendered for an Emergency Medical Condition are covered at the Network level of benefits if choice of Hospital was beyond the control of the plan participant.* | | |
| **Urgent Care Clinic & Physician Services**<br>-Freestanding Facility & Hospital | Covered at 100% after deductible | Not Covered |
| **Convenience Care Clinics**<br>***Note: All charges must be on the same bill and incurred on the same day of service*** | $10 Co-pay then covered at 100% up to a maximum of $100 per visit | |
| **Surgery**<br>Inpatient Hospital<br>Outpatient Hospital<br>Ambulatory Surgical Facility<br>*Includes surgeon, assistant surgeon anesthesiologist services.* | Covered at 100% after deductible | Not Covered |
| **Home Health Care**<br>Limited to 100 visits per Calendar Year | Covered at 100% after deductible | Not Covered |
| **Hospice Care**<br>***Note:*** *The maximum facility room rate will be the Semi-Private Room Rate.* | Covered at 100% after deductible | Not Covered |
| **Durable Medical Equipment** | Covered at 100% after deductible | Not Covered |
| **Physical Therapy** | Covered at 100% after deductible | Not Covered |
| **Occupational Therapy** | Covered at 100% after deductible | Not Covered |
| **Speech Therapy** | Covered at 100% after deductible | Not Covered |
| **Outpatient Radiation/Chemo Therapy**<br>-Hospital, Freestanding Facility or Physician's Office | Covered at 100% after deductible | Not Covered |
| **Prosthetics** | Covered at 100% after deductible | Not Covered |
| **Orthotics**<br>***Note:*** *Excluding orthopedic shoes or other devices for support of the feet.* | Covered at 100% after deductible | Not Covered |

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount.** | | |
| **Chiropractic Services** | Covered at 50% up to a maximum of $500 per Calendar Year (deductible waived) | Not Covered |
| **Ambulance Services** | Covered at 100% after deductible | Not Covered |
| **Mental Disorders/Substance Abuse** | Benefits are the same as those stated under each Covered Services category | Not Covered |
| **Vision Benefits**<br>***Note:*** *Allowed one (1) vision exam per Calendar year. The benefit is limited to $50.00 per Calendar year. All other services are provided at a discount through the Outlook Vision Discount Network.* | Covered at 50% up to a maximum of $50 per Calendar Year<br>(deductible waived)<br>(not subject to Non-Network Allowable Amount) | |
| **Brand Name Prescription Drugs** | After the $10,000 maximum benefit is reached, Plan Participant must pay for Brand Name prescriptions and file a claim with Entrust. Claims will be covered at 75% coinsurance (deductible waived). | |
| **Employee Assistance Program (EAP)**<br>Limited to 6 Free Visits per Emotional Situation<br>*Benefits provided by Interface EAP 1-800-324-4327* | | |
| **All Other Covered Medical Expenses** | Covered at 100% after deductible | Not Covered |
| **Acupuncture** | Not Covered | Not Covered |
| **Massage Therapy** | Not Covered | Not Covered |
| **Temporomandibular Joint Syndrome (TMJ)** | Not Covered | Not Covered |

## PRESCRIPTION DRUGS

| | 30 DAY SUPPLY | *RETAIL 90 |
|---|---|---|
| GENERIC | $5 Co-pay | $15 Co-pay |
| BRAND NAME | 25% Co-pay | 25% Co-pay |

*** Retail 90 allows you to purchase a 90 day supply of maintenance drugs at participating retail pharmacies**

***There is an annual maximum of $10,000 for Brand Name Drugs per plan participant through the Prescription Card Program. Once the $10,000 limit has been reached, Plan Participant must pay for the Brand Name prescriptions and submit claims to Entrust. The receipts submitted will be considered at 75% coinsurance (deductible waived).***

***Note:*** *If a brand name drug is dispensed, for any reason, other than a physician's RX (DAW), when a generic equivalent is available, the co-pay will be the Brand Name Co-pay plus the difference in cost between the Brand Name drug and the Generic equivalent. If no Generic is available, the Brand co-pay will apply.*

*There will be no benefits for the private purchase of outpatient prescription drugs, unless they are provided to a Participant as an inpatient, provided to a Participant by a facility as "take home" medications, administered to a Participant while the Participant is an outpatient, or purchased by the Participant prior to the Participant's receipt of their Prescription Drug Card. The Medically Necessary medications that are excluded under the Prescription Drug Program will be covered under the major medical portion of this Plan.*

# SCHEDULE OF BENEFITS

## PLAN B

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **Calendar Year Deductible**<br>Per Individual<br>Per Family<br>*(co-payments do not apply)* | <br>-0-<br>-0- | <br>$750<br>$1,500 |
| **THE CALENDAR YEAR DEDUCTIBLE WILL BE WAIVED FOR ALL SERVICES WITH A CO-PAYMENT, UNLESS OTHERWISE SPECIFIED.** | | |
| **Coinsurance** | 80% | 60% |
| **Maximum Out-of-Pocket Coinsurance**<br>Per Individual<br>Per Family | <br>$3,000<br>$6,000 | <br>$6,000<br>$12,000 |
| **The Maximum Out-of-Pocket Expense for Network and Non-Network Providers is combined.** | | |
| **Annual Maximum Amount** | $2,000,000 | |
| **Lifetime Maximum Amount**<br>*All Medical Benefits* | Unlimited | |
| ***Note:*** *For Medically Necessary Services rendered by a Network or Non-Network Provider, the benefits of this Plan will be provided after the deductible has been met until the out-of-pocket amounts are reached each Calendar Year. Thereafter, this Plan will provide benefits at 100% of the Allowable Amount for the remainder of the Calendar Year for all covered medical expenses, unless otherwise specified. Any balances of charges not covered by this Plan will be your responsibility to pay. The deductible and co-payments do not accrue towards the maximum out-of-pocket expense.* | | |
| **Covered Services** | **Network Providers** | **Non-Network Providers** |
| **The Allowable Amount for Network Providers is the contracted discounted amount. The Allowable Amount for Non-Network Providers is based on a limited fee schedule.** | | |
| **Physicians Office Visit**<br>Includes all related services performed plus allergy testing and treatment, x-rays and laboratory, in-office surgery<br>*Charges must be on same bill and incurred on the same day of service* | $20 Co-pay, then covered at 100% | Covered at 60% after deductible |
| **Routine Preventive Care**<br>Includes routine annual physical examinations, prostate exams, colon cancer screenings, gynecological exam, pap smear, mammogram, x-rays, laboratory and immunizations after age 6 | $15 Co-pay, then covered at 100% up to $300 maximum per Calendar Year | Covered at 60% after deductible |
| **Immunizations to age 6** | Covered at 100% | |
| **Outpatient Diagnostic Testing, Laboratory and/or Radiology**<br>(Hospital and Freestanding Facility)<br>(Excludes Emergency Room)<br>(Includes CT Scan, MRI, and PET Scan) | $20 Co-pay, then covered at 100% | Covered at 60% after deductible |

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount. The Allowable Amount for Non-Network Providers is based on a limited fee schedule.** | | |
| **Maternity Care**<br>Covered Employee & Spouse | Benefits are the same as those stated under each Covered Services category | Benefits are the same as those stated under each Covered Services category |
| **Hospital Service – Inpatient/Outpatient**<br>Daily Room and Board limited to the charges up to the semi-private room rate<br>Intensive Care Unit limited to Hospital's ICU charge | Covered at 80% | Covered at 60% after deductible |
| **Skilled Nursing Facility - Inpatient Services**<br>Covered at the lesser of the following:<br>(a)The daily charge of the regular daily charge for a semi-private room in the Hospital from which the patient was discharged or (b) $350 per diem<br>Limited to 100 days per Calendar Year | Covered at 80% | Covered at 60% after deductible |
| **Hospital Confinement for Rehabilitation**<br>*Note: Covered maximum daily allowable amount of $850 subject to pre-authorization and/or case management.* | Covered at 80% | Not Covered |
| *Covered services provided by a Non-Network radiologist, anesthesiologist, pathologist or other Physician over whom the Plan Participant had no control in selecting while receiving care (Inpatient/Outpatient) from a Network Hospital will be payable at the Network level of benefits.* | | |
| **PRE-AUTHORIZATION/UTILIZATION REVIEW**<br><br>**Only the following services must be pre-authorized:**<br>**Inpatient hospital confinements**<br><br>**Pre-authorization is not required for Inpatient maternity confinements within the minimum stay requirements.**<br>**Proper Authorization must be obtained in a timely manner**<br>**It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Pre-authorization/Utilization Review requirements.**<br>**Please see the Medical Management section of this booklet for details.** | | |
| **Emergency Room**<br>**Hospital & Physician Services**<br>Medical Emergency/Accidental Injury<br>*(co-pay waived if admitted as in-patient)* | $75 Co-pay, then covered at 100% up to a maximum of $300 per visit, then covered at 80% | Covered at 60% after deductible |
| ***Note:** Non-Network Emergency Services rendered for an Emergency Medical Condition will be payable at the Network level of benefits if choice of Hospital was beyond the control of the plan participant.* | | |

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount. The Allowable Amount for Non-Network Providers is based on a limited fee schedule.** | | |
| **Urgent Care Clinic & Physician Services**<br>(Freestanding Facility & Hospital) | Covered at 80% | Covered at 60% after deductible |
| **Convenience Care Clinics**<br>***Note: All charges must be on the same bill and incurred on the same day of service*** | $10 Co-pay then covered at 100% up to a maximum of $100 per visit | |
| **Surgery**<br>Inpatient Hospital<br>Outpatient Hospital<br>Ambulatory Surgical Facility<br>*Includes surgeon, assistant surgeon anesthesiologist services.* | Covered at 80% | Covered at 60% after deductible |
| **Home Health Care**<br>Limited to 100 visits per Calendar Year | Covered at 80% | Covered at 60% after deductible |
| **Hospice Care**<br>***Note:*** *The maximum facility room rate will be the Semi-Private Room Rate.* | Covered at 80% | Covered at 60% after deductible |
| **Durable Medical Equipment** | Covered at 80% | Covered at 60% after deductible |
| **Physical Therapy** | Covered at 80% | Covered at 60% after deductible |
| **Occupational Therapy** | Covered at 80% | Covered at 60% after deductible |
| **Speech Therapy** | Covered at 80% | Covered at 60% after deductible |
| **Radiation and/or Chemo Therapy**<br>Performed Outpatient or in the Physicians Office | Covered at 80% | Covered at 60% after deductible |
| **Prosthetics** | Covered at 80% | Covered at 60% after deductible |
| **Orthotics**<br>***Note:*** *Excluding orthopedic shoes or other devices for support of the feet.* | Covered at 80% | Covered at 60% after deductible |
| **Chiropractic Services** | Covered at 50% up to a maximum of $500 per Calendar Year<br>Deductible waived<br>(*not subject to Non-Network Allowable Amount*) | |

| Covered Services | Network Providers | Non-Network Providers |
|---|---|---|
| **The Allowable Amount for Network Providers is the contracted discounted amount. The Allowable Amount for Non-Network Providers is based on a limited fee schedule.** | | |
| **Ambulance Services** | Covered at 80% | Covered at 60% after deductible |
| **Vision Benefits**<br>***Note:*** *Allowed one (1) vision exam per Calendar year. The benefit is limited to $50.00 per Calendar year. All other services are provided at a discount through the* ***Outlook Vision Discount Network.*** | Covered at 50% up to a maximum of $50 per Calendar Year<br>(deductible waived)<br>(not subject to Non-Network Allowable Amount) | |
| **Mental Disorders/Substance Abuse** | Benefits will be the same as those stated under each Covered Services category | Benefits will be the same as those stated under each Covered Services category |
| **Brand Name Prescription Drugs** | After the $10,000 maximum benefit is reached, Plan Participant must pay for Brand Name prescriptions and file a claim with Entrust. Claims will be covered at 75% coinsurance (deductible waived). | |
| **Employee Assistance Program (EAP)**<br>Limited to 6 Free Visits per Emotional Situation<br>*Benefits provided by Interface EAP 1-800-324-4327* | | |
| **All Other Covered Medical Expenses** | Covered at 80% | Covered at 60% after deductible |
| **Acupuncture** | Not Covered | Not Covered |
| **Massage Therapy** | Not Covered | Not Covered |
| **Temporomandibular Joint Syndrome (TMJ)** | Not Covered | Not Covered |

## PRESCRIPTION DRUGS

| | 30 DAY SUPPLY | *RETAIL 90 |
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*There will be no benefits for the private purchase of outpatient prescription drugs, unless they are provided to a Participant as an inpatient, provided to a Participant by a facility as "take home" medications, administered to a Participant while the Participant is an outpatient, or purchased by the Participant prior to the Participant's receipt of their Prescription Drug Card. The Medically Necessary medications that are excluded under the Prescription Drug Program will be covered under the major medical portion of this Plan.*

# ELIGIBILITY REQUIREMENTS

**Eligible Classes of Employees**
All Employees of the Employer, including Fire and Police.

**Eligibility Requirements For Employee Coverage**
A person is eligible for Employee coverage on the date of hire provided the Employee:

(1) is a Full-Time Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

**Eligibility Requirements for Retirees of the Employer**
A Plan Participant is eligible to purchase Retiree coverage upon meeting the following requirements:

(1) has retired from the City of Kingsville, including Fire and Police; and
(2) is entitled to receive retirement benefits from the Texas Municipal Retirement System; and
(3) The Plan Participant notifies the Plan that the Plan Participant is electing to purchase retiree coverage no later than the day that the Plan Participant retires from the City of Kingsville; and,
(4) The Plan Participant is not eligible for group health benefits coverage through another employer.

The retiree coverage is the same level of coverage provided to current Plan Participants, or the Plan Participant may continue coverage at a reduced level if the Plan offers such option. The Plan may substitute Medicare supplement health benefits coverage for a Plan Participant, after the date that the Plan Participant becomes eligible for federal Medicare benefits.

Employees who were eligible to join the Plan but are not Plan Participants, but are otherwise still eligible through hours worked and Full-Time employment will be treated as Timely Enrollees during the first 31 days after this Plan is subject to HIPAA.

For purposes of completing the waiting period, an Employee who is on an Approved Leave of Absence will still be treated as a Full-Time Employee. Eligibility for coverage under the Plan shall continue during an approved Leave of Absence, for a period not to exceed the actual period of Leave, just as though the covered Employee was still a Full-Time Employee of the Employer. ***This provision does not provide a Participant with a Leave of Absence; rather, it is merely an attempt to coordinate with the Employer's policies.***

Once an Employee meets the eligibility requirements and becomes eligible for Employee coverage, the Employee remains in the eligible classes of Employees as long as the Employee is a Full-Time Employee.

Further, an Employee is considered a Full-Time Employee on each day of a regular paid vacation and on each regular non-working day if the Employee was a Full-Time Employee on the last preceding regular work day.

**Eligible Classes of Dependents**
Dependent is any of the following persons:
A covered Employee's Spouse, and Dependent children from birth to the limiting age of 26 years provided that the Dependent child is not eligible to enroll in an employer sponsored plan other than a group health plan of a parent. When a Dependent child reaches the limiting age, coverage will end on the date of the child's birthday. The Plan Administrator may require documentation to determine eligibility status of a Dependent child. This provision does not include Dependent grandchildren. Dependent grandchildren must meet the eligibility requirements in subsection number two below.

A Plan Participant may elect retiree coverage for his/her Dependents who had coverage under the Plan at the time that the Plan Participant retires, or the Plan Participant may discontinue coverage for one or more Dependents. A dependent who was not covered under the Plan at the time that the Plan Participant retired is not eligible for retiree coverage.

**Continuation during a student's serious illness or injury.** In the event that a Dependent child becomes seriously ill or injured while enrolled at a post-secondary institution of higher education and because of the onset of the illness or injury, a leave of absence is taken or some other change in student enrollment status is made, then the child's participation in the Plan will continue until the earlier of:

(1) one year after the first day of the medically necessary leave of absence; or
(2) the date on which his/her participation in the Plan would otherwise end under the terms of the Plan.

Continued participation in the Plan applies only if the Plan Administrator receives written certification:

(a) from a treating physician of the Dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change in student enrollment status) is medically necessary; and,
(b) from the institution of higher education which states the date on which the leave of absence (or other change in student enrollment status) became effective.

A Dependent child whose benefits are continued under this provision will be entitled to the same benefits during the leave of absence as if the Dependent child continued as a student at the institution of higher education and was not on a medically necessary leave of absence.

If health care benefits change during the Dependent child's medically necessary leave, and the Plan continues to cover Dependent children, then the new benefits for the Dependent child will continue for the remainder of the Dependent child's medically necessary leave until terminated by the time limits above or as long as the benefits are in effect, whichever is earlier.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Stepchildren or Foster Children who reside in the Employee's household may also be included.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents provided such child (or children) is primarily dependent on the Employee.

Notwithstanding any Plan provision to the contrary, the Plan will provide benefits to dependent children placed with Plan Participants or beneficiaries for adoption as required by the federal Omnibus Budget Reconciliation Act of 1993 and the Child Support Performance and Incentive Act ("CSPIA"). The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption to the child. The Omnibus Budget Reconciliation Act, as well as, CSPIA requires coverage of these pre-adoptive children and no Pre-Existing Conditions provisions are applied to coverage. The child must be available for adoption and the legal process must have been commenced.

As required by CSPIA, any child of a Plan Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied. *See the Qualified Medical Child Support Order (QMCSO) section for more details.*

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code. The Employer may require documentation-proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(1) Any unmarried child of the covered Employee's child (i.e. covered Employee's grandchild) if that unmarried child is younger than 25 years of age and, at the time application for coverage of the unmarried child of the covered Employee's child is made, is a dependent of the covered Employee for federal income tax purposes. Coverage for the unmarried child of the covered Employee's child may not be terminated solely because the covered child is no longer a dependent of the covered Employee for federal income tax purposes.

(2) A covered Dependent child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

**These persons are excluded as Dependents**: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

# ENROLLMENT

**Enrollment Requirements**

An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also, including coverage for newborn children.

**Newly Acquired Dependents and Dependents Becoming Eligible Other Than During Group Enrollment**

A newly acquired Eligible Dependent (other than a newborn child and a newly adopted child) shall be covered on the first day of the month following the day on which he/she first becomes eligible.

**Newborn Children and Newly Adopted Children of Covered Employee**

If the addition of the child would cause a higher contribution from the Employee, the child is **NOT** automatically covered at birth, adoption or placement for adoption. In order to be covered timely, the covered Employee must submit a Transaction/Change Card to the Plan Sponsor within thirty-one (31) days of the birth, adoption or placement for adoption. Otherwise, the child will not be allowed to enter the plan until the next Open Enrollment Period or if he/she has a Special Enrollment Provision.

If the addition of the child would not cause a higher contribution from the Employee, the child is automatically covered at birth, adoption or placement for adoption. In order to update the Plan eligibility file, and avoid any claim delays, the Employee must submit a Transaction/Change Card to the Plan Sponsor within thirty-one (31) days following the birth, adoption or placement for adoption.

If the Dependent(s) decline(s) enrollment when first eligible because of other health coverage, and eligibility for or employer contributions toward the cost of the other coverage terminates, they may in the future be able to enroll in this Plan, provided that they submit an Enrollment Form within thirty (30) days after such other coverage ends. The Dependent(s) will then be treated by the Plan as if the Subscriber was a "new hire," meaning coverage will be effective on the first day of the month following the month the other coverage lapsed, assuming a timely submission of the Enrollment Form. If the Dependent(s) decline(s) enrollment for any other reason during the period they were first eligible, they will not be able to enroll in the Plan until the next Open Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

**Timely and Late Enrollments**
An enrollment is either "timely" or "late":

**Timely Enrollment** – The enrollment will be "timely" if the completed form is received by the Employer no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

**Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late enrollees will not be allowed to enroll under the Plan unless they enroll during an Open Enrollment Period or during a Special Enrollment Period. However, if an eligible Employee or eligible Dependent is able to enroll "late" due to a Special Enrollment Period, then the eligible Employee or Dependent, by law, cannot be considered as a "late enrollee" and thus must be considered to have "timely enrolled".

If an eligible Employee or eligible Dependent enrolls "late" under the Plan, then that eligible Employee or eligible Dependent will be subject to an eighteen (18) month Pre-Existing Condition Limitation Period, as opposed to a twelve (12) month Pre-Existing Condition Limitation Period if the eligible Employee or eligible Dependent had "timely" enrolled (See Pre-Existing Condition Section for more details). However, this does not apply to an eligible Employee or eligible Dependent enrolling "late" due to a Special Enrollment Period. If this occurs, then the eligible Employee or eligible Dependent will only be subject to the twelve (12) month Pre-Existing Condition Limitation Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The enrollment date for a Late Enrollee is the first day of coverage. Thus, the time between the dates a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

# SPECIAL ENROLLMENT PERIOD

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the date of the first day of coverage is not treated as a waiting period.

(1) **Individual losing other coverage**
An Employee (or Dependent) who is eligible, but not enrolled in this Plan, may enroll if any of the following conditions are met:

(a) The Employee (or Dependent) was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee (or Dependent) who has lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated.

(d) The Employee requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

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

(2) **Dependent beneficiaries. If . . .**

(a) The Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan) and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period, and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption. .

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

(3) **Loss of coverage under Medicaid or a state child health plan**

An Employee or a Dependent may enroll if the following conditions are met:

(a) An Employee or a Dependent loses coverage under Medicaid or a state child health plan.

(b) The Employee requests enrollment of the Employee and any Dependents in the Plan not later than sixty (60) days after the date the coverage ends under Medicaid or the state child health plan.

(4) **Gaining eligibility for premium assistance under Medicaid or a state child health plan**

An employee or a Dependent may enroll if the following conditions are met:

(a) An Employee or a Dependent becomes eligible for financial assistance from Medicaid or a state child health plan.

(b) The Employee or a Dependent requests enrollment of the Employee and any Dependents no later than sixty (60) days after the date that Medicaid or the state child health plan determines that the Employee or any Dependents are eligible for such financial assistance.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption. Any Late Enrollee who enrolls during a Special Enrollment will be treated as if he or she had timely enrolled.

## SPECIAL ENROLLMENT PERIOD (PPACA)

The Patient Protection and Affordable Care Act (PPACA) created a Special Enrollment Period to enroll Dependents up to the age of 26 years and eligible Employees who previously reached a lifetime maximum limit under the Plan. The Special Enrollment Period begins on the date that the notice of the right to a Special Enrollment Period was sent to Employees, specifically September 1, 2010. The Special Enrollment Period ends on Sept 30, 2010. During this one-time Special Enrollment Period, Employees have the opportunity to enroll or re-enroll Dependents up to the limiting age of 26 years.

An Employee not covered by the Plan on September 1, 2010 who is otherwise eligible for the Plan, must enroll in the Plan if the Employee wishes to also enroll a Dependent under the age of 26.

The PPACA Special Enrollment Period is available only to a Dependent child under the age of 26 who is **not eligible to enroll or currently enrolled in, an employer sponsored plan other than a group health plan of a parent who is an Employee of the Plan Sponsor**.

## OPEN ENROLLMENT

During the open enrollment period, eligible Employees and their eligible Dependents (if applicable) not previously enrolled under the Plan will be able to enroll for coverage; and, covered employees and their covered dependents (if applicable) will be able to change some of their benefit decisions based on which benefits and coverage(s) are right for them. A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage(s). Plan Participants will receive detailed information regarding open enrollment from their employer.

Benefit choices made during the open enrollment period will become effective on the Plan's Anniversary Date and remain in effect unless the Employee or Dependent qualifies to enroll during a Special Enrollment Period (please see the "SPECIAL ENROLLMENT PERIODS" subsection under the "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS" section). Coverage Waiting Periods and Pre-Existing Conditions Limits are waived during open enrollment for covered Employees and covered Dependents changing from one plan to another plan or from one Preferred Provider Organization (PPO) Network to another PPO.

Any Late Enrollees enrolling during Open Enrollment will be subject to the eighteen (18) month Pre-Existing Condition Limitation Period (See Pre-Existing Condition Section for more detail).

# EFFECTIVE DATE

**Effective Date of Employee Coverage**
An Employee will be covered under this Plan as of the date that the Employee satisfies all of the following:

(1) The Eligibility Requirements; and
(2) The Enrollment Requirements of the Plan.

**Effective Date of Dependent Coverage**
A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

(1) in the case of marriage, as of the date of marriage;
(2) in the case of a Dependent's birth, as of the date of birth; or
(3) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

# TERMINATION OF COVERAGE

**When Employee Coverage Terminates**
Employee coverage will terminate on the earliest of the following dates:

(1) The date the Plan is terminated or the end of the month of Employee's termination of employment.
(2) The end of the month in which the covered Employee ceases to be in one of the Eligible classes. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)
(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option.

**Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff**
A person may remain eligible for a limited time if full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

**For disability leave only:** the end of the ninety (90) day period that next follows the date the person last worked as a Full-Time Employee.
**For leave of absence or layoff only:** the date the Employer ends the continuance (not to exceed a maximum of ninety (90) days).

While continued, coverage will be that which was in force on the last day worked as a Full-Time Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. The 90 day period will run concurrently with FMLA, as applicable.

**Continuation During Family and Medical Leave**
Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer 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.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions Limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

**Rehiring a Terminated Employee**
A terminated Employee, who is rehired more than ninety (90) days after the prior date of termination, will be treated as a new hire and be required to satisfy all Eligibility and enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment-waiting period.

**Employees on Military Leave**
An Employee who is absent from work for more than thirty (30) days in order to fulfill a period of duty in the Uniformed Services of the United States has a Qualifying Event as of the first day of the Employee's absence for such duty, and thus is eligible for rights under USERRA. The Plan Sponsor shall furnish to the Employee a notice of the right to elect continuation coverage under USERRA and shall afford the Employee the opportunity to elect such coverage in accordance with USERRA. If the Employee elects coverage, the right to that coverage ends on the earlier of: A) on the day after the deadline for the Employee to apply for reemployment with or return to active employment with the Employer or B) twenty-four (24) months beginning on the date of the employee's absence from employment with the Employer.

However, during the first thirty (30) days that the Employee is absent in order to fulfill a period of duty in the Uniformed Services of the United States, the Employee must be treated the same as any other employee. This means the higher USERRA premium cannot be collected from the Employee for the first thirty (30) days. After the Employee has been absent for more than thirty (30) days, the Employee will receive immediate USERRA coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Further, the Employee will have no preexisting condition exclusions applied by the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

In many instances, an Employee eligible for continuation of coverage under USERRA will also be eligible for continuation of coverage under COBRA. To the extent allowed under the law, the continuation of coverage periods under COBRA and USERRA will run concurrently under the plan.

Plan exclusions and waiting periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**When Dependent Coverage Terminates**

A Dependent's coverage will terminate on the earliest of the following dates:

(1) The date the Plan is terminated.
(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
(3) The date Dependent coverage is terminated under the Plan.
(4) The date on which he or she ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option.

**Certificates of Creditable Coverage**

The Plan will provide a Certificate of Creditable Coverage to any Plan Participant after the individual loses coverage in the Plan. In addition, if coverage was lost prior to 7/1/97, a Certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

# QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Pursuant to CSPIA, Employers are required to develop administrative procedures for handling QMCSOs. This Section sets forth the procedures to be followed by The Employee Health Benefit Plan as sponsored by the Employer shown in Appendix A.

A QMCSO is a court judgment, decree, or order, or a state administrative order that has the force and effect of law and is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an "alternate recipient," the child of a participant. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is "qualified." A QMCSO may apply to the self-funded health plan, the self-funded dental plan (if any), and the health care spending account (if any). In general, an alternate recipient child under a QMCSO is to be treated like any other child of a Plan participant.

These orders (QMCSO) are usually drafted by attorneys for the divorcing couple or by the state child support agency. There is no standard format required; however, each order must contain certain information specified by CSPIA.

In some cases, orders will be based on state laws enacted in response to Section 1908 of the Social Security Act, which requires states to enact certain child support laws, or face the loss of federal

Medicaid funds. These state laws are designed to help state governments obtain private-sector coverage for children who would otherwise be eligible for state Medicaid coverage. Both the state and the non-employee parent can obtain a court order to force coverage under the plan, even if the employee is not interested in obtaining plan coverage for the child.

**Plan's Rights and Responsibilities**
All actions related to QMCSOs must be made in conformance with these procedures and must be performed on a timely basis.

The Plan is not required to provide coverage in accordance with a child support or other court orders that are not "qualified" in accordance with CSPIA. The Employer has the ultimate authority to determine whether or not the order meets all of the requirements of CSPIA. If the order does not meet all of the qualification requirements, the plan need not and will not provide any benefits to the alternate recipient child, unless the parties later correct the deficiencies.

**Plan Procedures for handling QMCSOs**

(1) Upon receipt of an order, the Employer must:
   (a) Promptly send written notice of the receipt of the order to the participant and all alternate recipient children named in the order.
   (b) Review the order to determine if it meets the legal requirements of QMCSO.
(2) Within a reasonable time of the receipt of the order, the Employer must notify the participant and alternate recipient children that either:
   (a) The order is a valid QMCSO; or
   (b) The order is not a valid QMCSO (including an explanation of what provisions are defective or missing).
(3) Any disputes raised by the parties are to be referred to the Plan's legal counsel.
(4) If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order. If an amended order is submitted, the evaluation process is reinitiated for the new order.

**Administrative Guidelines**
An order will be considered "qualified" upon receipt and approval of the following:

(1) The name and last known mailing address of each alternate recipient. In some cases, a state agency will be named in place of the child.
(2) A "reasonable description" of the type of coverage or benefits provided by the Plan.
(3) The period of time to which the order applies.
(4) The identification of each plan to which the order applies.

The order cannot require the Plan to provide any benefits not currently being provided under the Plan, or to alter the Plan's eligibility requirements.

# MEDICAL BENEFITS

Medical Benefits apply when covered medical charges are incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

**Network Provider Plan**
The Plan offers a Preferred Provider Organization (PPO) network for certain services. This Plan has entered into an agreement with a PPO Network(s) that have agreements with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to reduce their fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, that Plan Participant will receive a higher percentage reimbursement from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use. Note: Plan A does not have any Non-Network benefits.

When a Plan offers a PPO, you may see any provider you desire. However, your benefits may be reduced if you choose a Non-Network provider. (Network benefits will be paid for a Non-Network Provider if a Network Provider, **capable of providing the required medical services,** is not located within a 50-mile radius of the Covered persons' residence.) The amount eligible for payment consideration will be the lesser of the actual charge, the discounted charge, an agreed negotiated amount between the parties, the prevailing charge or the charge the Plan Administrator deems Reasonable and Necessary for the Plan.

**It is the responsibility of the Plan Participant to determine whether their provider of choice is currently in or out of the network used by their plan.**

**Please note: Network providers may change networks and the Network Directory or web site may not always reflect a providers' current status. Therefore, it is always advisable to call the PPO's Customer Service Department to verify the current status of the provider. The name, phone number and web site of your PPO Network, if applicable, are shown in the attached Appendix A. A list of Network Providers in your area is available by contacting the Employer Plan Sponsor, or a complete listing is available by accessing the web site listed in Appendix A.**

**DEDUCTIBLE**
Deductibles are dollar amounts that the Plan Participant must pay before the Plan pays and do not apply toward maximum out-of-pocket expenses or lifetime maximums.

**PLAN A:**
**Family Monthly Deductible.** A family monthly deductible is an amount of money that is paid every Calendar Month per individual or per Covered Family Unit. The family monthly deductible amount must be paid before any money is paid by the Plan for any covered services. At the first of each calendar month, a new deductible amount is required.

**Family Unit Limit.** When the dollar amount shown in the Schedule of Benefits has been incurred by the member(s) of a Family Unit toward their family monthly deductible, the deductible of all members of that Family Unit will be considered satisfied for that calendar month. If there is only one member in a family, i.e. a participant in the plan without any covered dependents, then the family monthly deductible remains the same.

**PLAN B:**

**Calendar Year Deductible.** A Calendar Year deductible is an amount of money that is paid once a Calendar Year per Plan Participant. 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 January 1st, a new deductible amount is required.

**Deductible Three-Month Carryover.** Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

**Deductible For A Common Accident.** This provision applies when two or more Plan Participants in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit.

**CO-PAYMENT**

Co-payments are dollar amounts that the Plan Participant must pay before the Plan pays and do not apply toward maximum out-of-pocket expenses or lifetime maximums.

A co-payment is a smaller amount of money that is paid by the plan participant each time a specified service is used (*see Schedule of Benefits*). Typically, there may be co-payments on some services and other services will not have any co-payments

**Physician Office Visit Co-payment.** The Physician Office Visit Co-payment applies to Covered Expenses for charges made by a Network Physician for services and supplies given in connection with an office visit. The amount of the Physician Office Visit Co-payment is shown in the Schedule of Benefits.

This Co-payment does not apply to prenatal and postnatal office visits to the Network OB/GYN who is primarily responsible for your maternity care.

**Non-Network Hospital Confinement Co-payment.** Applies to each confinement in a Non-Network Hospital. The amount of the Hospital Confinement Co-payment is shown in the Schedule of Benefits. It applies separately to you and each of your Dependents. This Co-payment is separate from all other Co-payments and Deductibles, which apply under the Plan. Covered Expenses, which count toward this Co-payment, do not count toward any other Deductible under the Plan.

The Hospital Confinement Co-payment does not apply to Hospital confinements for newborn children, which begin at birth.

**BENEFIT PAYMENT**

Each Plan Year, benefits will be paid for the covered charges of a Plan Participant. Payment will be made at the rate shown in the Schedule of Benefits.

## COVERED MEDICAL EXPENSES

Covered charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the "Benefit Limits" of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

If a hospital has only private rooms, the allowable is 90% of the lowest private room rate.

**Intensive Care and Progressive Care** charges will be covered to the hospital's usual charge.

(2) **Hospital Confinement for Rehabilitation.** The charges for confinement in an acute Hospital for Physical or Occupational rehabilitation will be covered up to $850 per diem. There must be a medical necessity for the confinement and there must be a qualifying stay of 3 days and there is a maximum stay of 14 days per illness, injury, or disability. Additionally, the patient must be able to participate in the therapy and must be a potential for recovery.

Pre-authorization is required and the confinement is subject to case management.

Any confinement for rehabilitation that is primarily for therapy is not covered.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;
(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days;
(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
(d) the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Plan Participant's care in these facilities is counted as Covered Expenses up to the lower of the following:

(i) The facility's regular daily charge for a semi-private room.
(ii) 50% of the regular daily charge for a semi-private room in the Hospital from which the patient was transferred.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services. This includes pharmacologic management for mental and nervous conditions.

(5) **Assistant Surgeon Services.** Covered Expenses for services of an assistant surgeon are limited to 20% of the amount of Covered Expenses for the surgeon's charge for the surgery.

(6) **Multiple surgical procedures.** Covered Expenses for multiple surgical procedures performed at one operative session are limited as follows:

(a) Covered Expenses for the second procedure are limited to 50% of the Covered Expenses for the secondary procedure.

(b) Covered Expenses for any subsequent procedure are limited to 50% of the Covered Expenses for the subsequent procedure

*Note:* An Assistant Surgeon's (M.D.) eligible charges will be considered at 20% of the chief surgeon's allowable fee. If a Licensed Surgical Assistant is eligible under the definition of Physician in this Document, those services will be considered at 15% of the chief surgeon's allowable fee.

(7) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) Outpatient Nursing Care. Charges are covered only when care is **Medically Necessary** and not Custodial in nature.

(8) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or 4 hours of home health aide services.

(9) **Hospice/Home Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than 6 months and placed the person under a Hospice Care Plan. Services and supplies for Hospice Care are subject to case management approval.

(10) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local **Medically Necessary** professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest

Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless the Plan Administrator finds a longer trip was **Medically Necessary**.

(b) Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) Cardiac rehabilitation as deemed **Medically Necessary** provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(e) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

(f) Initial contact lenses or glasses required following cataract surgery.

(g) Rental of durable medical or surgical equipment if deemed **Medically Necessary**. These items may be bought rather than rented, but only if agreed to in advance by the Plan Administrator.

(h) Laboratory studies.

(i) The initial purchase, fitting, repair and replacement of orthotic appliances such as braces, splints or other appliances, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(j) Injectable contraceptives such as Depo-Provera or Lunelle.

(k) Prescription Drugs (as defined).

(l) The initial purchase, fitting, repair and replacement of fitted prosthetic devices, which replace body parts.

(m) Sterilization procedures.

(n) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

(o) Diagnostic x-rays.

(p) PET Scans, but only if approved under case management as Medically Necessary. PET Scans are limited to two (2) per Calendar Year, unless approved under an Alternative Care Program (See Alternative Care Program below).

## EMERGENCY SERVICES

**Emergency Services** means, with respect to an Emergency Medical Condition, treatment or services for an Injury or Illness that is of serious, life-threatening nature, developing suddenly and unexpectedly, and demanding immediate treatment that is within the capability of the emergency department of a Hospital to evaluate such Emergency Medical Condition and to stabilize the patient.

**Emergency Medical Condition** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions placing the health of the individual (or unborn child) in serious jeopardy.

For Medically Necessary Emergency Services rendered by a Network or a Non-Network provider, this Plan will provide benefits as specified in the Schedule of Benefits. Any balance of charges not covered by this Plan will be your responsibility to pay.

**INJURY TO OR CARE OF MOUTH, TEETH AND GUMS**

Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
(2) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth.
(4) Excision of benign bony growths of the jaw and hard palate.
(5) External incision and drainage of cellulites.
(6) Incision of sensory sinuses, salivary glands or ducts.
(7) Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

**OCCUPATIONAL THERAPY**

Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness that occurred while covered under the Plan and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**PHYSICAL THERAPY**

Physical therapy by a licensed physical therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness that occurred while covered under the Plan and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**SPEECH THERAPY**

Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

**DURABLE MEDICAL EQUIPMENT**

Charges for durable medical equipment will be payable as described in the Schedule of Benefits and may be subject to case management.

**PROSTHETICS/ORTHOTICS**
Charges for prosthetics/orthotics will be payable as described in the Schedule of Benefits and may be subject to case management.

**CHIROPRACTIC SERVICES/SPINAL MANIPULATION**
Chiropractic services/Spinal manipulation will be paid as shown in the Schedule of Benefits and may be subject to case management.

**MEDICAL DEVICES/IMPLANTS**
Charges for medical devices/implants will be limited to1) an amount equal to the actual net cost of the medical device/implant paid by the hospital or other provider plus an amount up to but not to exceed 50% of said cost, or 2) the PPO discounted amount, whichever is less. However, no amount will be paid by the Plan for a medical device/implant that exceeds $1,000 per item until the specific medical device/implant invoice is submitted to the Plan by the hospital or other provider showing evidence of the actual net cost of the medical device/implant paid by the hospital or other provider.

**EMPLOYEE ASSISTANCE PROGRAM (EAP)**
A clinically trained care coordinator and/or crisis counselor will be available to eligible Plan Participants and their eligible Dependents 24 hours a day via a national toll-free number to assist with any calls of a crisis nature. Supervisors may also call upon the EAP to assist in problem identification, documenting impaired job performance, intervention with a problem employee, and other concerns.

Sessions with a licensed counselor (not to include a psychiatrist) will be on an as needed basis, and will be free of charge to eligible Plan Participants and their dependents. The number of sessions provided to Plan Participants will be 6 per person per family problem. Each Plan Participant has his/her own coverage, but if more than one member of the Family Unit is seeking counseling for the same problem, available sessions are not increased for that problem. For example, if both spouses are seeking counseling for marital problems, 6 sessions would be available, not 12 because two family members are participating. However, if during the assessment, the counselor discovers that one of them has a separate problem, that eligible Dependent spouse may seek counseling for that problem (and have up to 6 sessions) with another provider. The EAP will be used first to obtain an assessment of the problem. If the problem is short term, additional EAP sessions will be available for the person(s) seeking help. If the problem is long term, a referral to the appropriate program(s) could be made prior to exhausting the full 6 EAP sessions. If further treatment is needed that is not covered under the Plan, Interface will work to make available that treatment at a reduced cost to the family.

Referrals for legal problems and financial planning are provided. Each eligible Plan Participant has a maximum of 3 consultations with an attorney per Calendar Year. The consultations with an attorney may be either in person or via telephone with the first 30 minutes at no charge. Additional services with the attorney are provided at a reduced rate. Plan Participants will have 3 financial planning sessions per Family Unit, per Calendar Year. All services are provided via telephone.

**TREATMENT OF MENTAL DISORDERS**
Psychiatrists (M.D.), psychologists (Ph.D.), or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must bill the Plan through these professionals.

**TREATMENT OF SUBSTANCE ABUSE**
Benefits under this provision concerning Substance Abuse will be payable only upon the diagnosis and recommendation of a Physician and only for expenses for treatment recognized by the medical profession as appropriate methods of effective treatment of Substance Abuse.

*Effective Treatment of Substance Abuse* means a program of Substance Abuse therapy that meets all of the following tests:

(a) It is prescribed and supervised by a Physician; and
(b) The Physician certifies that a follow-up program has been established which includes therapy by a Physician, or group therapy under a Physician's direction.

Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the aftereffects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol-free or drug-free environment.

If the conditions for effective treatment are met, Covered charges for care, supplies and treatment of Substance Abuse are payable as follows:
(1) If a Plan Participant is confined as an inpatient in a Hospital solely for treatment of complications of Substance Abuse (cirrhosis of the liver or delirium tremens) or if such inpatient in a Hospital that does not have a section which is a Substance Abuse treatment facility, Hospital expenses incurred during any such confinement will be considered Covered Expenses as if for any other sickness.
(2) If a Plan Participant is not confined in a Hospital or treatment facility, charges for the Outpatient treatment of Substance Abuse are covered under Medical Benefits for Substance Abuse Treatment.
(3) Psychiatrists (M.D.), psychologist (Ph.D.), or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

**COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS**

*1.* ***INTERLINK Exclusive Provider Organization (EPO) Network Benefits***
The Plan includes a Centers of Excellence (COE) transplant benefit and offers transplant benefits to eligible candidates through the INTERLINK Health Services ("INTERLINK") TransplantCOE EPO network. Coverage for transplant services rendered at an INTERLINK credentialed TransplantCOE program will be paid at 100% of eligible hospital, professional and organ/marrow charges according to contract terms negotiated by INTERLINK. Co-payments, deductibles and other member responsibilities still apply. To view the current list of eligible TransplantCOE transplant providers, please visit www.interlinkhealth.com/TransplantCOE. **Other than as provided in paragraphs 3 and 4 below, the Plan does not cover organ/marrow/tissue transplants outside of the Interlink Exclusive Provider Organization Network.**

2. ***Covered Transplants*** Include solid organs (heart, lung, liver, pancreas, kidney, multi-visceral/small bowel, or any combination thereof as a multi-organ transplant), bone marrow, stem cell and islet transplants.

3. ***Emergency Transplant Care At NON-INTERLINK TransplantCOE Providers***
Coverage for unplanned and unscheduled emergency transplantation ("Emergency Transplant") is a benefit included in the Plan, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of the emergency transplant, then the transplant shall be paid at 110% of Medicare allowable and be considered payment in full. The transplanting hospital must provide the following documents to INTERLINK, who will then forward them onto the Plan, within 24 hours of the Emergency Transplant:

a) A letter from the transplanting hospital's Surgical Director detailing the medical conditions leading to the Emergency Transplant
b) A copy of the United Network For Organ Sharing ("UNOS") Status 1 Listing Request and Status 1A confirmation Notice From UNOS; and,
c) A detailed contract proposal for the Emergency Transplant.

4. ***Medical Hardships Proposed Transplant Care: NON-EPO Transplant Exceptions***
The Plan may approve non-TransplantCOE transplant care for documented Medical Hardship cases, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of Provider's billing proposal to Plan, then payment shall be paid at 110% of Medicare allowable and shall be considered payment in full. Medical Hardship, as used here, could include such instances where the patient may be too medically frail to travel, re-transplantation following a successful transplant by the same transplant team, or a living donor hardship. For consideration, Medical Hardship forms must be submitted to INTERLINK within 3 business days of the Plan being contacted for transplant benefits or approval for evaluation. All information will be forwarded to the Plan for consideration. For Medical Hardship transplant benefit consideration, the transplant center must complete and submit the following forms:

a) A letter from the Surgical Director to the Plan detailing the medical conditions supporting the Medical Hardship;
b) A completed Medical Hardship Form: *Key Outcome Indicators Worksheet;*
c) A completed Medical Hardship Form: *Transplant Billing Report Table* for the prior three years of transplant billing history; and,
d) A detailed contract proposal for the proposed Medical Hardship transplant. Medical Hardship Forms can be downloaded from: www.interlinkhealth.com/medicalhardship

***5. Pre-Authorization Requirement for Organ Transplant*****
Covered Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist.
As soon as reasonably possible after a Covered Person's physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or Covered Person's physician should contact the Plan Administrator for referral to the medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be submitted for this Plan's medical review, and should include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year

prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the Plan's medical review specialist.) Additional attending physician's statements may also be required. A non-network hospital may provide a comprehensive treatment plan independent of the EPO, but this will be subject to a Medical Hardship review and may result in no benefit coverage for the transplant at that center. **All potential transplant cases will be assessed for their appropriateness for Case Management. **Failure to pre-authorize a non-emergency transplant procedure will result in the application of a $5,000 deductible to all Covered Expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements that would normally be applicable to the transplant procedure.**

*6.* ***Organ Transplant Network***

As a result of the pre-authorization review, the Covered Person will be asked if they wish for assistance gathering information about participating transplant programs. The term "participating transplant program" means "a licensed healthcare facility and transplant program that has met INTERLINK's Quality Assurance Program standards for participation, and been declared a TransplantCOE program by INTERLINK Health Services' Quality Assurance Committee. The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure using some of the nation's most experienced and qualified transplant teams.

*7.* ***Transplant Benefit Period***

Covered Expenses will accumulate during a Transplant Benefit Period. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date, which is twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

8. ***Covered Transplant Expenses***

The term "Covered Expenses" with respect to transplants includes the reasonable and necessary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

a) Charges incurred in the evaluation, screening, and candidacy determination process;
b) Charges incurred for organ transplantation;
c) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

(i) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;
(ii) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care;
(iii) If the transplant procedure is a hematopoetic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs

of the stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period);

(d) Charges incurred for follow up care, including immuno-suppressant therapy; and

(e) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual (over age 21), or in the event that the recipient or the donor is a minor (under age 21), two (2) other individuals (also over age 21). In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

*9.* ***Re-Transplantation***

Re-transplantation will be covered up to one re-transplant, for a total of two transplants per person, per lifetime.

*10.* ***Donor Expenses***

In-Network Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network; this does not include the donor's transportation and lodging expenses.

**ROUTINE PREVENTIVE CARE**
**(Applicable to Network benefits only)**

Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits, limited to once per year.

**Charges for Routine Well Care.** Routine well adult care includes care by a Physician that is not for an Injury or Sickness.

**Charges for Well Child Care.** Well childcare includes routine pediatric care and immunizations by a Physician that is not for an Injury or Sickness.

**COVERAGE OF WELL NEWBORN NURSERY/PHYSICIAN CARE**

**Charges for Routine Newborn Nursery Care.** Routine well newborn nursery care is room, board and other normal care, including a surgeon's charge for circumcision for which a Hospital makes a charge.

The Allowable Charge made by the Hospital for routine nursery care provided as shown below after the newborn child's birth will be considered as covered charges under the Plan.

This coverage is only provided if a parent is a Plan Participant who was covered under the Plan at the conclusion of the Pregnancy and the newborn child is an eligible Dependent and is nether injured nor ill.

Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a

Cesarean section will be 96 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuers for prescribing a length of stay not in excess of 48 hours (or 96 hours for Cesarean delivery).

**Charges for Routine Physician Care.** The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

**COVERAGE OF PREGNANCY**

The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for the Employee and the Spouse only. Pregnancy expenses for a dependent child are not covered under this Plan.

Coverage for a Hospital stay following a normal vaginal delivery will be 48 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Coverage for a Hospital stay in connection with childbirth following a Cesarean section will be 96 hours for both the mother (if a Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. 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 for Caesarean delivery). **(Federal Newborn and Mothers Health Protection Act)**

**PRE-EXISTING CONDITIONS**

**Note: The length of a Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has creditable coverage from another health plan.**

**An eligible person may request a certificate of creditable coverage from his or her prior plan. The Employer will assist any eligible person in obtaining a certificate of creditable coverage from a prior plan.**

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred after the person has been covered under this plan for 12 consecutive months (18 months if a late enrollee) from his or her enrollment date. The waiting period is counted towards the Pre-Existing Conditions 12-month or 18-month exclusion time.

**Waiver of the Pre-Existing Condition Limit.** This waiver applies to the benefits of persons who were covered under a prior terminated plan on its day of termination and became covered under this Plan on the effective date of this Plan provided that any person that became covered under this Plan has had 12 months of prior creditable coverage under the terminated plan. If the person now covered has less than 12 months of prior creditable coverage, then the Pre-Existing Condition Limitation will be reduced, day for day, by the length of prior creditable coverage shown on the certificate of creditable coverage.

**The prior plan** means the plan of benefits that was provided through the Employer and is replaced by this Plan.

**No Loss/No Gain.** The amount of time these persons were covered under the previous plan will be credited toward the Pre-Existing Conditions time limit of this Plan.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of a person's Enrollment Date. For these purposes, Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests, or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to Pregnancy.

**EFFECT OF PRIOR CREDITABLE COVERAGE**
The following provision applies only to Covered Employees (and Covered Dependents, if the Certificate provides coverage for them) who, prior to coverage under the Plan, were covered as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Plan will automatically cover any such person under the Plan on its Effective Date, subject to the following provisions: Those persons eligible according to the terms of the Plan will be covered at the level of benefits of the Plan. The limitations for Pre-Existing Conditions will be waived to the extent the Pre-Existing Conditions requirement has been satisfied under the prior Creditable Coverage.

Days of Creditable Coverage that occur before a Significant Break in coverage will not be counted in reducing the Pre-Existing Condition limitation. A Significant Break in coverage means a period of 63 consecutive days during all of which the Plan Participant did not have any Creditable Coverage. An employment-waiting period will not apply towards a period of Creditable Coverage or be used in determining a Significant Break.

**No Pre-existing condition exclusions up to age 19.** The Plan will not impose a pre-existing condition exclusion on an eligible Employee or Dependent child who is under the limiting age of 19. For the purposes of this section, Pre-existing condition exclusion means a limitation or exclusion of benefits (including the denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

# MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is NOT covered:**

**Acupuncture.** Services for acupuncture that is not **Medically Necessary** and not provided by a Physician (M.D.).

**Charges incurred outside the United States.** Charges incurred outside the United States if the Covered Participant traveled to such location for the purpose of obtaining medical services, medications, or supplies.

**Childhood conditions.** Conditions related to childhood behavioral problems such as autistic disease, hyper kinetic syndromes, learning disabilities, mental retardation, other behavioral problems, and conditions related to childhood inpatient confinement for environmental change. However, this exclusion shall not apply to charges incurred for prescription drugs for or in connection with such condition(s), nor for the following medically necessary services rendered solely for medication checks required as a result of taking such medication for the treatment of ADD/ADHD: (1) Physician office visit(s), and (2) laboratory examination(s).

**Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan. Complications that represent a danger to the Participant's life will be considered Eligible Medical Expenses subject to pre-authorization and documented as Medically Necessary.

**Contraception.** A charge for contraceptive devices, contraceptive materials, or oral contraceptive medications, except as may be included under the prescription drug benefit.

**Cosmetic services.** Services or supplies to improve appearance or self-perception which do not restore a bodily function, including but not limited to cosmetic or plastic surgery, hair loss or skin wrinkling, unless **Medically Necessary**. This exclusion will not apply if the care and treatment is for:

a. Repair of disfigurement resulting from and accidental injury sustained by the patient and treatment is begun within ninety (90) days after the accident in which the injury is sustained, unless it was not possible to do so within this time limit; or
b. Treatment for correction of a congenital defect of a child less than 19 years of age.

**Custodial care.** Services or supplies provided mainly as a rest cure or maintenance care such as sitters, homemaker services, education or training.

**Dental.** Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic, or oral surgical charges unless expressly included elsewhere in this Plan document

**Detoxification.** Treatment solely for detoxification or primarily for maintenance care is not considered effective treatment. Detoxification is care aimed primarily at overcoming the after effects of a specific drinking or drug episode. Maintenance care consists of the providing of an alcohol-free or drug-free environment.

**Developmental Delay or Learning Disability.** Services, supplies or treatment (including, but not limited to psychodiagnostic evaluation) for developmental delay or learning disability.

**Driving Under the Influence.** Charges incurred when the Plan Participant was driving a motor vehicle and his/her blood-alcohol level is over the legal limit in the state where the Plan Participant

was driving. ***A final determination of guilt by a court of law is not necessary for this exclusion to apply.***

**EAP and Behavioral health.** Employee Assistance and behavioral health services are excluded unless specifically shown in the Schedule of Benefits.

**Educational or Vocational testing.** Services for educational or vocational testing or training.

**Excess charges.** Where the Plan does not have a pre-payment or preferred provider agreement with a medical provider, charges which exceed the Reasonable and Necessary charges of the individual or organization for the services, medicines, or supplies furnished.

**Exercise programs.** Exercise or therapy programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by the Plan.

**Experimental or Investigational Services/Treatments.** Procedures, drugs or research studies, or for any services or supplies that are not considered legal in the United States or whose use is limited to experimental or investigational purposes by laws or regulations under State or Federal law.

**Eye care.** Lasik, radial keratotomy or other eye surgery to correct nearsightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

**Foot care.** Care and treatment of:

a) weak, strained, flat, unstable or unbalanced feet;
b) superficial lesions of the feet such as corns, calluses or hyperkeratoses; tarsalgia, metatarsalgia or bunion, except Surgery which involves exposure of bones, tendons or ligaments; and
c) toenails, except removal of nail matrix; and
d) arch supports, heel wedges, lifts, the fitting or provision of Orthotics or orthopedic shoes, except as an integral part of a brace.

This exclusion does not apply to the initial office visit nor treatment of a metabolic or peripheral-vascular disease.

**Government coverage.** Services or supplies received in a hospital owned or operated by the United States government, State government or any of its agencies, except to the extent, if any, that charges are made for such services or supplies which the plan participant would be required to pay if this plan were not in affect. This exclusion shall not apply where Federal law mandates this plan to provide coverage. (See also Medicare/Medicaid)

**Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

**Hazardous Hobby.** Care and treatment of an injury or illness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity, which is characterized by constant

threat of danger or risk of bodily harm. Examples of hazardous activities include, but are not limited to, skydiving, auto racing, snowmobile racing, motorcycle racing, jet ski racing, hang gliding, bungee jumping, or rodeo activities.

**Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. This exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is the result of a surgical procedure.

**Hospital confinement.** Inpatient admissions when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, and any routine physical examination or test performed while the participant is an inpatient and which are not connected with the actual illness or injury.

**Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

**Hypnosis.** Treatment by hypnosis or any type of goal-oriented or behavior modification therapy, such as to (but not limited to) quit smoking or weight loss, except as part of the Physician's treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.

**Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. Also includes services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. ***A final determination of guilt by a court of law is not necessary for this exclusion to apply.***

**Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of, or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances.

**Infertility/Impotence.** Care and treatment for infertility, artificial insemination, surrogate mother or in vitro fertilization. Fertility drugs, contraceptives, sex transformations, and reversal of a sterilization procedure. Male impotence medications, phosphodiesterase type inhibitors, including but not limited to Viagra or other sildenafil citrate medications.

**Massage Therapy.** Charges for massage therapy (other than for treatment of an illness or injury and consistent with an approved treatment plan) when not prescribed by a Physician or provided by a licensed provider. See definition of Physician.

**Medical Devices/Implants**

Charges for medical devices/implants will be limited to1) an amount equal to the actual net cost of the medical device/implant paid by the hospital or other provider plus an amount up to but not to exceed 50% of said cost, or 2) the PPO discounted amount, whichever is less. However, no amount will be

paid by the Plan for a medical device/implant that exceeds $1,000 per item until the specific medical device/implant invoice is submitted to the Plan by the hospital or other provider showing evidence of the actual net cost of the medical device/implant paid by the hospital or other provider.

**Medicare/Medicaid.** For any condition, disease, aliment, injury or diagnostic service to the extent that benefits could be provided by Medicare or any other tax supported or government program except when State or Federal law requires this Plan to pay primary to benefits of such programs. In no event shall the benefits of this program paid under provision of law exceed the lesser of the benefits of this program in absence of such tax supported or government program(s).

**Missed Appointment.** Charge for missed appointment, completion of claim forms or providing medical information to determine coverage, and/or charges for telephone consultation are not covered under this Plan.

**No charge.** Services or supplies for which the covered person is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

**Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

**No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

**No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.

**Not specified as covered.** Services, treatments and supplies, which are not specified as covered under this Plan.

**Nuclear exposure.** Any illness or injury caused by atomic explosion or other release of nuclear energy whether or not the result of war.

**Nutritional supplements.** Nutritional supplements not necessary for the treatment of an accident or illness.

**Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.

**Occupational.** Care and treatment of an Injury or Sickness that is occupational (i.e. arises from work or any employment for wage or profit including self-employment) and is reimbursable under a Workers' Compensation or similar program.

**Personal comfort items charges (when hospital confined).** Personal comfort items or other equipment, such as, but not limited to, television, telephone, beautification items, admission kits, air

conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

**Physicians' charges.** Charges for physicians' fees for any treatment which are not ordered or rendered by or in the physical presence of a licensed physician. This exclusion shall not apply to automated lab fees.

**Plan Design exclusions.** Charges excluded by the Plan Design as mentioned in this document.

**Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.

**Professional nursing services.** Charges for professional nursing services, except as listed in the Schedule of Benefits, if rendered by someone other than an **RN** (registered graduate nurse) or a **LPN** (licensed practical nurse).

**Relative giving services.** Professional services performed by a Physician (see definition of Physician) who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

**Replacement braces.** Replacement of braces for the leg, arm, back, neck, or artificial arms or legs unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

**Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

**Self-Inflicted.** Charges incurred in connection with any intentionally self-inflicted injury or illness, suicide or attempted suicide, but only if the injuries do not result from a physical or mental illness or domestic violence.

**Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

**Sex changes.** Care, services or treatment for non-congenital transsexuals, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, and hormone therapy, and surgery, medical or psychiatric treatment.

**Sleep disorders.** Care and treatment for sleep disorders unless deemed **Medically Necessary**.

**Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.

**Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

**Temporomandibular Joint Syndrome.** Charges for all diagnostic, surgical and non-surgical treatment services related to the treatment of jaw problems including temporomandibular joint (TMJ) syndrome.

**Travel** or accommodations, except as may be indicated in the plan, whether or not recommended by a physician, except for ambulance charges as defined as a covered expense.

**War.** Charges incurred as a result of war or any act of war, declared or not; or caused during service in the armed forces of any country except as required by the Uniformed Services Employment and Re-employment Right Act.

# PRESCRIPTION DRUG BENEFITS

*Note: If a brand name drug is dispensed, for any reason, other than a physician's RX (DAW), when a generic equivalent is available, the co-pay will be the Brand Name Co-pay plus the difference in cost between the Brand Name drug and the Generic equivalent. If no Generic is available, the Brand co-pay will apply.*

***There will be no benefits for the private purchase of outpatient prescription drugs, unless they are provided to a Participant as an inpatient, provided to a Participant by a facility as "take home" medications, administered to a Participant while the Participant is an outpatient, or purchased by the Participant prior to the Participant's receipt of their Prescription Drug Card. The Medically Necessary medications that are excluded under the Prescription Drug Program will be covered under the major medical portion of this Plan.***

## PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Plan Participant's reduced fees for covered Prescription Drugs.

## CO-PAYMENT

The co-payment is applied to each covered pharmacy drug charge and is shown in the Prescription Drug Program Schedule of Benefits. The co-payment amount is not a covered charge under the Medical Plan. Any one prescription is limited to a 30-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Plan Participant's ID Card is not used, the amount payable in excess of the co-payment will be the ingredient cost and dispensing fee.

## COVERED PRESCRIPTION DRUGS

(1) Legend prenatal vitamins;
(2) Legend vitamins;
(3) Compounded Medications;

(4) Contraceptives (Oral/Topical/Intravaginal – this includes Ortho Bvra, Ortho Novum, Nuva Ring, TriPhasil);
(5) Immunosuppressants, with prior authorization;
(6) Insulin, by prescription only, and Insulin syringes;
(7) Diabetic test strips;
(8) Lancets;
(9) Acne Agents, including Retin-A, prior authorization necessary after age 25;
(10) HIV- and AIDS-related medications;
(11) Flu Medications limited to a 5 day supply per prescription (not covered under mail order);
(12) Self Administered Injectables (e.g. Ana Guard, Ana-Kit, Aranesp, D.H.E. 45, Enbrel, Epipen, Epogen, Glucagen, Interferons, Lovenox, Leukine, Methotrexate, Nuepogen, Procrit) (not covered under mail order);
(13) Insomnia – Sleeping Agents (e.g. Ambien, Restoril, Sonata) – limited to 90 per 144 days and limited to 30 per script;
(14) Migraine Medication – Injectables (limited to 8 injections per 25 days)/Nasal Sprays (Limited to 8 sprays per 25 days)/Oral (Limited to 18 tabs per 25 days);
(15) ADHD/Narcolepsy Medication (e.g. Dexedrine, Ritalin, Cylert), covered through age 19;
(16) Zyvox, limited to 14 days supply per prescription;
(17) Schedule V drugs (e.g. Phenergan w/ codeine, Robitussin A-C, Tussi-Organidin-S);and
(18) Other drugs which, by state law, may only be dispensed upon the written prescription of a physician or other lawful prescriber, and must be FDA approved, must not be experimental, and must not be investigational.

**LIMITS TO THIS BENEFIT**

This benefit applies only when a Plan Participant incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician
(2) Refills up to one year from the date of order by a Physician.

**CLINICAL PRIOR AUTHORIZATION PROGRAM**

The following prescription drugs will only be covered after obtaining Clinical Prior Authorization:

(1) Anabolic Steroids – Injectable/Oral/Topical;
(2) COX 2 Inhibitors (allowed 30-day supply per 365 days before required to obtain a Clinical Prior Authorization).

**PRESCRIPTION DRUGS NOT COVERED**

This benefit will not cover a charge for any of the following:

(1) Over the counter drugs and products;
(2) Acne agents, including Retin-A after the age of 25 without prior authorization;
(3) Contraceptives (Abortive, Emergency, Implantable, Injectable);
(4) Diaphragms;
(5) Fluoride Preps (Oral Fluoride);
(6) Drugs to treat sexual inadequacies;

(7) Growth hormones;
(8) Fertility agents;
(9) Smoking Deterrents;
(10) Anorexiants;
(11) Anti-Obesity Medications (used for weight loss);
(12) Cosmetics;
(13) Blood Glucose Testing Machines;
(14) Impotency Medications;
(15) Biological Injectables (allergens, serums, vaccines);
(16) Tikosyn;
(17) Medical devices/supplies;
(18) Miscellaneous Medical Supplies – Legend;
(19) Therapeutic devices or appliances, including support garments, and other non-medicinal substances, regardless of the intended use;
(20) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
(21) Drugs labeled "Caution: limited by federal law to investigational use" or experimental drugs;
(22) Any charge for the administration of prescription legend drugs or injectable Insulin;
(23) Any medication which is consumed or administered at the place where it is dispensed;
(24) Drugs covered under Workers' Compensation;
(25) Schedule I controlled substances.

# ASK A NURSE

## PERSONAL HEALTH MANAGEMENT
## PHONE: 1-877-463-3435

Your Employer is introducing a benefit to help you and your family with questions and concerns about medical care. Ask a Nurse/Personal Health Management, a service offered by Medical Helpline not only provides you with the surgical and hospital authorizations you have always needed, but can now provide you with information, education, and counseling about medical issues you may be facing. This program is staffed by Registered Nurses ready to help you.

Ask a Nurse/Personal Health Management helps you find doctors and facilities that are members of your PPO Network. When you use a network provider for medical services you are protected against uncontrolled medical costs, which you may otherwise have to pay.

**There is no cost to you to use Ask a Nurse/Personal Health Management**

When you call the toll free line **1-877-463-3435**, you will have access to a comprehensive health information program that combines confidential, non-directive health care decision counseling by registered nurses, medical information and easy to read educational material, as well as authorization for planned inpatient services.

After speaking with the nurse, you will be better informed and able to make wiser choices concerning the health care services you use. The nurse can provide you with information in English or Spanish.

The nurse does not replace your doctor, but she or he will help improve communication with your doctor. Doctors have spent many years in medical school, read medical journals, and attend conferences to keep up with the latest medical information. You may think you have nothing to contribute to your own medical care. Think again! Doctors treat hundreds of patients a year. You are the expert when it comes to your family history, symptom lifestyle preferences, concerns and fears. By allowing Ask a Nurse/Personal Health Management to help you do your homework and by fully understanding the benefits, risks and costs to you of a proposed treatment, you can select the option best suited to your needs. Few medical procedures are actually emergencies, there is usually time to explore your options and select the one that best suits you.

Nurses are available to you 24 hours a day. You may contact them as frequently as you wish. Your calls are kept strictly confidential and since records are maintained once you have made the first call, the nurse is able to give more personalized counseling.

We are pleased to offer you the Employer-sponsored Ask a Nurse/Personal Health Management program and have designed it to assist you in making educated decisions about you and your family's health.

# MEDICAL MANAGEMENT SERVICES

**Medical Management Services Phone Number (877) 463-3435**

The patient, a family member or service provider must call this number to receive certification of certain Medical Management Services. This call must be made at least five (5) business days in advance of services being rendered or within two (2) business days after an emergency.

**PRE-AUTHORIZATION/UTILIZATION REVIEW**

Pre-authorization/Utilization review is a program designed to help insure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

This program consists of:

(a) Pre-authorization of the Medical Necessity for the following non-emergency services:
- Hospitalizations

(b) Retrospective review of the Medical Necessity of the services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

**It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Pre-authorization/Utilization Review requirements.**

In order to maximize Plan reimbursements, please read the following provisions carefully.

**Here's how the program works.**

**Pre-authorization.** Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or receives other medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Plan Participant, family member or service provider. Contact the utilization review administrator at:

**Medical Helpline**
**(877) 463-3435**

At least five (5) business days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered employee.
- The name, Social-Security number and address of the covered employee.
- The name of the Employer.
- The name and telephone number of the attending Physician.
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay.
- The diagnosis and/or type of surgery.
- The proposed medical services to be rendered.

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact Medical Helpline within two (2) business days after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment.

Proper authorization must be obtained in a timely manner.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services. **It is ultimately the responsibility of the Plan Participant to make sure that the provider complies with the Pre-authorization/Utilization Review requirements.**

If the attending Physician feels that it is **Medically Necessary** for a Plan Participant to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

**VOLUNTARY SECOND AND/OR THIRD OPINION PROGRAM**

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Plan Participants and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

| | | |
|---|---|---|
| Appendectomy | Hernia Surgery | Spinal Surgery |
| Cataract Surgery | Hysterectomy | Surgery *(knee, shoulder, elbow or toe)* |
| Cholecystectomy *(gall bladder removal)* | Mastectomy Surgery | Tonsillectomy & adenoidectomy |
| Deviated Septum | Prostate Surgery | Tympanotomy |
| Hemorrhoidectomy | Salpingo oophorectomy *(removal of tubes/ovaries)* | Varicose Vein Ligation |

**PRE-ADMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be the Network and Non-Network coinsurance levels for diagnostic lab tests and x-ray exams when:

(1) Performed on an outpatient basis within seven days before a Hospital confinement;
(2) Related to the condition which causes the confinement; and
(3) Performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 100% even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

**CASE MANAGEMENT**

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps, lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate **Medically Necessary** Care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring Hospital or nursing home care;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

(1) The catastrophic Injury or Sickness must have occurred while the patient was covered.
(2) An alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for **Medically Necessary** expenses, as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

**Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

**ALTERNATIVE CARE PROGRAM**

In addition to the benefits specified, the Plan also offers benefits for services furnished by any provider to a Covered Person pursuant to an Alternative Care program. The Alternative Care program applies to a Covered Person who has suffered a personal injury, sickness, or other health condition while covered under the Plan. ***A "personal injury, sickness, or other health condition" is defined as an illness, injury, impairment, or physical or mental condition that involves outpatient care; or inpatient care in a hospital, hospice, or residential medical care facility; or continuing treatment by a health care provider.*** The Case Manager will coordinate and implement this Alternative Care program by providing guidance and information on available resources and suggesting the most appropriate alternative treatment plan. This alternative treatment plan must be approved by both the Plan and the Case Manager.

The Plan shall provide such alternative benefits for so long as it determines that alternative services are Medically Necessary and cost-effective. Severity of the Covered Person's personal injury, sickness, or other health condition and the prognosis will be taken into consideration. The Plan shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrifice to the quality of patient care. However, certain time and dollar amount limitations

may still apply to the approved alternative treatment plan even if the alternative services continue to be Medically Necessary and cost-effective.

If a covered person is accepted into an alternative treatment plan, the Plan will pay benefits for usual, customary and reasonable charges. The Plan will determine the amount of benefits, and said benefits may exceed policy limitations and may extend beyond the types of expenses covered by the Plan. However, in no event will benefits exceed the Individual Lifetime Maximum Benefit of the Plan.

Any agreement to pay benefits in accordance with the above will be based on an objective review of:

1. the covered person's medical status;
2. the current treatment plan;
3. the projected treatment plan;;
4. the long term cost implications; and
5. the effectiveness of care.

An alternative treatment plan may be terminated at any time, including, but not limited to, when the covered person has improved or deteriorated to the extent that the alternative services are no longer necessary and cost-effective, the individual's coverage under the Plan ends, or the Individual Lifetime Maximum Benefit has been reached.

An alternative treatment plan will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person. If an alternative treatment plan is provided for a Covered Person in one instance, the Plan shall not be obligated to provide the same or similar benefits for other covered persons under this Plan in any other instance, nor shall it be construed as a waiver of the right of the Plan thereafter in strict accordance with its express terms.

# CLAIMS PROCEDURES

**CLAIMS REVIEW PROCEDURE**

In cases where a claim for benefits payment is denied in whole or in part, the claimant may appeal the denial. This appeal provision will allow the claimant to:

(1) Request from the Plan Administrator a review of the eligibility status for any claim denied in whole or in part.

(2) Request from the Plan Administrator a review of any claim payment. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(3) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the claimant with a written response within 60 days of the date the Plan Administrator receives the claimant's written request for review and if not notified, the Plan Participant may deem the claim

denied. If, because of extenuating circumstances, the Plan Administrator shall notify the claimant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the claimant's written request for review.

The Plan Administrator's written response to the claimant shall cite the specific Plan provision(s) upon which the denial is based. A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

**HOW TO SUBMIT A CLAIM**

When a Plan Participant has a claim to submit for payment that person must:

(1) Obtain a claim form from the Personnel Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- a) Name of Plan
- b) Group Number of Plan
- c) Employee's Name
- d) Name of Patient
- e) Name, address, telephone number of the provider of care
- f) Diagnosis
- g) Type of services rendered, with diagnosis and/or procedure codes
- h) Date of services
- i) Charges

(5) Send the above to the Claims Administrator at this address:

Entrust, Inc.
P.O. Box 441588
Houston, TX 77244-1588

**WHEN CLAIMS SHOULD BE FILED**

Claims should be filed with the Claims Administrator within 12 months of the date charge for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Charges are considered incurred when a treatment or care is given or a procedure performed. Claims filed later than that date may be declined or reduced unless:

(1) it's not reasonably possible to submit the claim in that time; and

(2) the claim is submitted within one (1) year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested. A Plan Participant will be notified within 90 days as to the acceptance of a claim and if not notified within 90 days, the claim shall be deemed denied. This 90-day period may be extended at the request of the Plan Administrator.

**However, any claim for expenses incurred by a Covered Person in a Plan Year, which is received more than 90 days subsequent to the end of the Plan Year, will be considered ineligible due to late submission, only if such late submission limits the Plan's rights to recover for such expenses under any reinsurance or stop loss contract.**

# COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will either pay its regular benefits in full or a reduced amount which when added to the Plan or Plans, will in most cases, equal 100% of eligible expenses under the provisions of this Plan.

**Benefit Plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.
(2) Blue Cross and Blue Shield group plans.
(3) Group practice and other group prepayment plans.
(4) Federal government plans or programs. This includes Medicare.
(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable Charge.** For a charge to be allowable it must be a Reasonable and Necessary Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Plan Participant used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

**Benefit Plan Payment Order.** When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(a) The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the plan which covers the person as a dependent; except that; if the person is also a Medicare Beneficiary and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   (i) Secondary to the plan covering the person as a dependent, and
   (ii) Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the benefits of the Plan covering that person as other than a dependent.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid-off or retired are determined before those of a benefit plan which covers a person as a Dependent of a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid-off nor retired or a Dependent of an Employee who is neither laid-off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
   (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
   (ii) If both parents have the same birthday, the benefits of the benefit plan, which has covered the patient for the longer time, are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:
   (i) *This rule applies when the parent with custody of the child has not remarried.* The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
   (ii) *This rule applies when the parent with custody of the child has remarried.* The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
   (iii) *This rule will be in place of items (i) and (ii) above when it applies.* A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
   (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outline above when a child is covered as a Dependent and the parents are not separated or divorced.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**Claims Determination Period.** Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of allowable charges.

**Facility of Payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of Recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan has the right to recover the amount of the overpayment from the source to which it was paid.

# THIRD PARTY RECOVERY PROVISION

**Right of Reimbursement and Subrogation**

The Plan has certain special rights of subrogation and reimbursement that apply to all medical, dental, vision, and prescription drug benefits offered by the Plan. The Plan Administrator retains discretionary authority to interpret and enforce this and all other plan provisions and the discretionary authority to determine the amount of the lien.

Plan Participant, his or her attorney, and/or a legal guardian of a minor or incapacitated individual agree that acceptance of the Plan's conditional payment of benefits is constructive notice of and agreement to all the terms in this Third Party Recovery Provision.

**Defined Terms**

"Condition" means an injury, illness, sickness, or other condition.

"Recovery" means moneys paid to the Plan Participant by way of judgment, settlement, arbitration, or otherwise to compensate for all losses caused by injuries or sickness whether or not said losses reflect medical, dental, vision, or prescription drug charges covered by the Plan.

"Refund" means repayment to the Plan for medical, dental, vision or prescription drug benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue the Plan Participant's claims for medical, dental, or prescription drug charges against the other person, including a third party and a third party's insurer.

Note that Plan Participant, as referenced in this Third Party Recovery section, includes both Employees and any Dependents covered by this Plan.

**When this Provision Applies**

The Plan Participant may incur medical, dental, vision, or prescription drug charges due to injuries caused by the act or omission of another party. In such circumstances, the Plan Participant may have a claim for the payment of the medical, dental, vision, or prescription drug charges against another party. This includes another party's insurer, or any other source on behalf of that party; any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage; any insurance policy from any insurance company or guarantor of a third party; worker's compensation or other liability insurance company; or any other person, entity, or source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage (all of the above in this sentence collectively referred to as "Coverage").

When the Plan pays for expenses that were either the result of the alleged negligence or which arise out of any claim or cause of action which may accrue against any party responsible for the injury or death of the Plan Participant or any dependent of the Plan Participant by reason of their eligibility for benefits under the Plan, the Plan has a right to equitable restitution. Accepting benefits under this Plan for those incurred medical, dental, or prescription drug expenses automatically entitles the Plan to a lien on any amount recovered by the Plan Participant whether or not designated as payment for medical expenses. The Plan's lien applies to any amount recovered by the Plan Participant from another party or Coverage. These liens shall remain in effect until the Plan is repaid in full.

The Plan Participant agrees that the Plan will be immediately and first be reimbursed in full prior to the Plan Participant (or anyone else) receiving any monies recovered from another party or Coverage, or any other economic source; this provision applies regardless of any Plan Participant's fault or negligence and regardless of how any Plan Participant obtains recovery. In the event that another party or Coverage pays money directly to a Plan Participant or the Plan Participant's attorney, the Plan Participant and his or her attorney, for the exclusive benefit of the Plan, must hold any funds received as a result of any settlement, judgment, arbitration award, or otherwise, in constructive trust as soon as the funds are received. The Plan Participant is obligated to inform his or her attorney of the Plan's subrogation lien and to make no distributions which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The Plan Participant must direct his or her attorney or attorneys or any other person holding monies on his or her behalf to pay over such monies to the Plan in the full amount that the Plan has paid on the Plan Participant's behalf,

without any reduction in attorney's fees, legal fees, court costs, or any other costs or fees incurred in securing recovery, regardless of whether or not the Plan Participant is made whole.

The Plan may seek relief from anyone who receives settlement proceeds or amounts collected from judgments related to the condition. This relief may include, but is not limited to, the imposition of a constructive trust and/or an equitable lien. If the Plan Participant or any other beneficiary accepts payment from the Plan or has Plan benefits paid on the Plan Participant's behalf, that person does so subject to the provisions of the Plan, including the provisions described in this Right of Reimbursement and Subrogation Third Party Recovery section. Plan Participant, as well as any legal representative or guardian, shall be considered a constructive trustee with respect to any recovery received or that may be received, which was paid in consideration of any condition for which a party was responsible and which Plan Participant has received a benefit payment. Any such funds will be held in trust until the Plan's lien is satisfied.

**Obligations of Plan Participant**
The Plan Participant:

(1) Must repay to the Plan all benefits paid on his or her behalf by the Plan out of the recovery made from another party or Coverage; and
(2) Understands that the Plan has no obligation to share in the legal fees incurred by the Plan Participant or dependent in securing any third-party recovery (See below); and
(3) Understands that the Plan's right of reimbursement and subrogation will apply regardless of whether the Plan Participant is fully compensated or made whole economically; and
(4) Agrees that he or she will keep the Plan Administrator up to date and current regarding any developments between the Plan Participant and another party and their Coverage; and
(5) Agrees that he or she will not release any party or his, her, or its insurer, without prior written approval from the Plan, and will take no action which prejudices the Plan's reimbursement and subrogation right; and
(6) Agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

The Plan has the right to the Plan Participant's full cooperation in any case involving the Plan Participant's recovery of medical, dental, vision, or prescription drug charges from another party or Coverage. In such cases, the Plan Participant is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce its rights in this provision.

Neither a Plan Participant, any member of any Plan Participant's family, nor anybody else at a Plan Participant's direction may do anything to harm the Plan's rights to subrogation and recovery. If a Plan Participant or an individual in the preceding sentence does not comply with any reasonable Plan request in this regard, the Plan may withhold benefits that otherwise may be due under the Plan, whether or not those benefits have anything to do with the subrogation, and a Plan Participant will be responsible to reimburse the Plan, in the Plan Administrator's discretion, for any costs incurred as a result of such action.

**Amount Subject to Subrogation or Refund**
The Plan may, but is not obligated to, take any legal action it sees fit against any person, party, entity, or otherwise to recover the benefits that the Plan has paid, including but not limited to intervening in any legal action of a Plan Participant and/or bringing a legal action against a Plan Participant, his or her attorney, and any party holding any proceeds relating to the Plan Participant. The Plan's exercise of this right will not affect the Plan Participant's right to pursue other forms of recovery unless the Plan Participant and his or her legal representative consent otherwise. Furthermore, the Plan Participant agrees that the Plan specifically has a priority over any attorney's fees, legal fees, court costs, or any other costs or fees incurred by the Plan Participant in recovering funds paid by another party Responsible Party or their Coverage. These attorney's fees, legal fees, court costs, or any other costs or fees are solely the responsibility of the Plan Participant. Additionally, the Plan Participant agrees that any attorney's fees, legal fees, court costs, or any other costs or fees incurred by the Plan or the Plan Sponsor in exercising the Plan's right to subrogation and reimbursement to recover funds paid by another party or Coverage are subject to the Plan's right of subrogation and will be included in the total amount reimbursed. **The Plan Participant clearly acknowledges that the Plan does not have any duty or obligation to pay a fee to the Plan Participant's attorney for the Plan Participant's attorney's services in making any recovery on behalf of the Plan Participant.**

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical, dental, vision, or prescription drug charges as well as any other costs and fees associated with the enforcement of its rights under the Plan.

**Recovery from Another Insurance Policy**
This right of refund and all of the provisions set forth in this Third Party Recovery Provision apply when a Plan Participant recovers from another responsible party or their Coverage. The Plan pays secondary to any and all Personal Injury Protection (PIP) insurance coverage, Med-Pay insurance coverage, or No-Fault insurance coverage. The Plan has no duty or obligation to pay any claims until PIP, Med-Pay, or No-Fault insurance coverage is exhausted. In the event that the Plan pays claims that should have been paid by PIP, Med-Pay, or No-Fault insurance coverage under this provision, then the Plan is entitled to recover from the Plan Participant the full amount of any monies received by the Plan Participant from any PIP, Med-Pay, or No-Fault insurance carrier.

**Death of Plan Participant**
When the Plan pays benefits, funds recovered by the Plan Participant, and funds held in trust over which the Plan has an equitable lien, exist separately from the property and estate of the Plan Participant, such that the death of the Plan Participant, or filing of bankruptcy by the Plan Participant, 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. In the event that the Plan Participant dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against another party or Coverage, the Plan's subrogation and reimbursement rights shall still apply.

**Assignment of Rights**
If the Plan Participant fails to pursue a claim against potentially responsible third parties, insurers, or any other person or entity and has accepted benefits under the Plan, the Plan is automatically assigned the Plan Participant's rights to recover payments from any third parties, insurers, or any other person or

entity. This subrogation right allows the Plan to pursue any claim which the Plan Participant has against any third party, any insurer, or any other person or entity regardless of whether or not the Plan Participant chooses to pursue that claim. This subrogation right applies to any condition arising out of or related to any act or omission that caused or contributed to the Injury or Sickness for which such benefits are to be paid.

**Minors**
In the event the injured Plan Participant is a minor, the minor's parents and/or legal guardians agree to all of the terms set forth in this Third Party Recovery Provision.

# RESPONSIBILITIES FOR PLAN ADMINISTRATION

**PLAN SPONSOR**
The Plan Sponsor will be one of the following: (1) the employer; (2) the employee organization; (3) a joint board of trustees; (4) an entity representing parties establishing or maintaining the Plan. For this Plan, the Employer is the Plan Sponsor. The Plan Sponsor shall be responsible for adopting the Plan and any amendments to the Plan and for creating a trust in which to hold the Plan assets. If the Plan Sponsor handles any of the Plan funds or other property, then the Plan Sponsor shall be required to be bonded with a fidelity bond.

**PLAN ADMINISTRATOR**
The Plan Administrator is an individual or a group of individuals usually named in the plan document that is responsible for the plan duties. The Plan Administrator may be an entity other than a natural person. If a Plan Administrator is not named in the plan document, then the Plan Sponsor is generally the Plan Administrator. For this Plan, the Employer is also the Plan Administrator. The Plan is to be administered by the Plan Administrator. An individual may be appointed by Employer to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Employer 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, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

**Duties of the Plan Sponsor**
(1) To formally adopt the Plan in writing and contains mandated provisions.
(2) To create a trust to hold all the Plan assets.
(3) To cause those employees that handle any of the Plan funds or other property to be bonded with a fidelity bond.

**Duties of the Plan Administrator**

(1) To administer the Plan in accordance with its terms.
(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
(3) To decide disputes which may arise relative to a Plan Participant's rights.
(4) To prescribe procedures for filing a claim for benefits and to review claim denials.
(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
(6) To appoint a Contract administrator to pay claims.
(7) To perform all necessary reporting.
(8) To disclose to the Employee all necessary documents.
(9) To establish and communicate procedures to determine whether a medical child support order is qualified.
(10) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

**Plan Sponsor and Plan Administrator Compensation**

Both the Plan Sponsor and Plan Administrator serve **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**Fiduciary**

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its' assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**Fiduciary Duties**

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstance that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
(3) In accordance with the Plan documents.

**The Named Fiduciary**

A "named fiduciary" is the one named in the Plan or identified by the Employer and/or an employee organization as a fiduciary by a procedure specified in the Plan. A named fiduciary has authority to control and manage the operations and administration of the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or
(2) The named fiduciary breached its fiduciary responsibility.

**Contract Administrator is not a Fiduciary**
A Contract administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

# SPECIAL PROVISIONS

## FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

**For Employee and Dependent Coverage.** The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. Funding is derived from the funds of the Employer and/or contributions made by the covered Employees. The Employee will pay, through payroll deductions, any required contributions on a pre-tax basis under a pre-tax plan.

A Plan Participant who elects retiree coverage for himself/herself and/or his/her Dependents must make payments in the same manner as other Plan Participants.

The level of any Employee contributions, if any, will be set by the Employer. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

**Benefit Payments.** Benefits are paid directly from the Plan through the Claim Administrator. The Claim Administrator does not contribute funds to pay benefits, nor does it have any liability to do so. Benefit payment checks issued to providers or participants are paid out of, and to the extent of, the funds received from the Employer and/or Employee contributions. The Claim Administrator's name may appear on the check; however, in no way should this be construed as any financial obligation on the part of the Claim Administrator.

## INTERPRETING THIS DOCUMENT

The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Summary Plan Description applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

## CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

## AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to 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). Only the Plan Administrator has the authority to amend the Plan. All amendments will be made via a written instrument signed by the Plan Administrator. Any amendments to the Plan will be implemented on the first of the month following the date the amendment is approved and signed by the Plan Administrator.

## DISPOSITION OF TRUST FUND UPON ANY TERMINATION

Upon termination of the Plan, the Trustee, in accordance with the Trust Agreement, shall apply all the remaining assets of the Trust Fund in a uniform and nondiscriminatory manner exclusively toward the provision of benefits and the administration of those there under for or on account of those persons enrolled in the Plan at the time of termination.

## CONFORMITY IN LAW

If any provision of this Plan is contrary to any federal, state, or local law to which it is subject, such provision is hereby amended to conform thereto.

## REVIEW AUTHORITY

The Plan Administrator shall have complete authority to review all denied claims for benefits under the Plan (including, but not limited to, the denial of certification of the medical necessity of hospital or medical treatment). In exercising its responsibilities, the Plan Administrator shall have discretionary authority 1) to determine whether and to what extent covered persons are eligible for benefits; and, 2) to construe disputed or doubtful Plan terms. The Plan Administrator shall be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

## LEGAL DISPUTES

If the Plan Participant makes any legal claim against the Plan or any Plan Fiduciary, all benefits provided under the Plan shall cease as to the complaining employee, until such time as the employee's legal action is resolved. This provision shall not be read as providing any more rights than any legal judgment in favor of the employee and against the Plan or any Plan Fiduciary. Should the Plan

Participant obtain a legal judgment against the Plan or the Employer, the amount of any such judgment shall be offset against the amount of benefits previously paid to the Participant for the disputed claim.

**LIMITATION OF LEGAL ACTIONS**
No action at law or equity will be brought to recover under the Plan prior to the expiration of sixty (60) days after Proof of Loss has been filed, as required by the Plan Document, nor will any action be brought unless within two (2) years from the expiration of that time within which Proof of Loss is required by the Plan Document.

**FRAUD AND MIS-STATEMENTS**
All coverage provided under the Plan is based on the truthfulness of statements made to the Plan by the Plan Participants, either in a written enrollment form or otherwise. Coverage can be voided for any Plan Participant, and/or any or all members of that Participant's covered family unit, for any misrepresentation or fraudulent misstatement made to the Plan, the Plan Fiduciaries or Entrust by the Plan Participant or any or all members of that Participant's covered family unit.

**PLAN PARTICIPANT/PROVIDER RELATIONSHIP**
The Plan does not furnish covered services, but only helps pay for covered services Plan Participants receive. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give covered services to Plan Participants.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY**
A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator/Employer Plan Sponsor.

**REMEDIES AVAILABLE FOR DENIED CLAIMS**
If a claim for benefits is denied by the Plan, you will receive a written explanation of the reason for the denial. You are then entitled to a review of this benefit determination if you have questions or do not agree with the reasons for the denial. To obtain a review, you must submit your request to the Plan in writing within 60 days following your receipt of the denial. Appeals received in Entrust's office more than 60 days following the date of the denial are not eligible to be reviewed and the original denial shall be final.

# IMPORTANT NOTICE OF PLAN PARTICIPANT RIGHTS

*Please carefully read the following important notices, which describe certain rights under Federal Law; of a plan participant*

## WHCRA ANNUAL NOTICE

The Women's Health and Cancer Rights Act of 1998 requires the City of Kingsville, the Employer/Plan Sponsor, to notify you, as a participant or beneficiary of the Employer/Plan Sponsor, of your rights related to benefits provided through the plan in connection with a mastectomy. You as a participant or beneficiary have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

(a) All stages of reconstruction of the breast on which the mastectomy was performed;
(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and treatment of physical complications of the mastectomy, including lymph edema.

These benefits are subject to the plan's regular deductible and co-pay as shown in the Schedule of Benefits.

Keep this notice for your records and call the City of Kingsville, for more information.

## MINIMUM MATERNITY BENEFITS STATEMENT

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

## RIGHT TO COBRA CONTINUATION

On April 7, 1986, a federal law (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)) was enacted requiring that most employers sponsoring group health plans offers employees and other members of their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end. This notice contains important information about your right to COBRA continuation. **This notice generally explains COBRA continuation coverage, when it becomes available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review your plan document or contact your Plan Administrator.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA continuation coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your 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 you or your Dependents fail to make timely payment of premiums. You should check with your Employer to see if COBRA applies to you and your Dependents.

"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 your Employer's plan) are not considered for continuation under COBRA.

**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 Beneficiary." You, your spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a covered Employee (meaning that you are an Employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your spouse.

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

- The parent-covered Employee dies;
- The parent-covered Employee's hours of employment are reduced;
- The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under the plan as a "Dependent child."

**The Employer must give notice of some Qualifying Events**
When the Qualifying Event is the end of employment, 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 Administrator of the Qualifying Event.

**You must give notice of some Qualifying Events**
Each covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator 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 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 under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Beneficiary entitled to receive COBRA 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 COBRA continuation coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

**Deadline for providing the notice**
For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

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

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of COBRA 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:

- The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
- The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's Summary Plan Description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (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 you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

**Who can provide the notice**
Any individual who is the covered Employee (or former Employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, 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 Beneficiaries with respect to the Qualifying Event.

**Required contents of the notice**
The notice must contain the following information:

- Name and address of the covered Employee or former Employee;
- If you already are receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, 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 Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce ;
- 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;
- 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);
- 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;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, 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;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary 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
- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination 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 the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request

additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

**Electing COBRA continuation coverage**

Complete instructions on how to elect COBRA continuation coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 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 Beneficiary 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 Administrator determines that the individual is not entitled to COBRA continuation coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

**How long COBRA continuation coverage lasts**

COBRA continuation coverage will be available up to the maximum time period shown below. 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), your divorce 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 Beneficiaries 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 8 months before the date on which his employment terminates, COBRA continuation coverage for his 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.

**Disability extension of 18-month period of COBRA continuation coverage**
If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your 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.

**Second Qualifying Event extension of 18-month period of COBRA continuation coverage**
If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your 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.

**When COBRA continuation coverage ends earlier than the maximum periods above**
COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your Employer ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary 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). However, a Qualified Beneficiary 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
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary 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.

**Payment for COBRA continuation coverage**
Once COBRA continuation coverage is elected, you 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.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible

individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the Qualified Beneficiary elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

**Additional Information**
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is:

City of Kingsville
200 East Kleberg
Kingsville, TX 78363

**Current Addresses**
In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

## HIPAA PRIVACY USES AND DISCLOSURES

The Health Insurance Portability Act of 1996 and its implementing regulations, 45 D.F.R. parts 160 through 164 (referred to herein as the "HIPAA Privacy Rule") requires that the Plan protects the confidentiality of your Protected Health Information ("PHI"). A complete description of your rights under the HIPAA Privacy Rule is available upon request from the Employer by contacting the Privacy Official.

This amendment is intended to bring the Plan into compliance with the requirements of the HIPAA Privacy Rule by establishing the extent to which the Employer will receive, use and/or disclose PHI. According, the Plan is hereby amended as follows:

### A. THE PLAN DESIGNATION OF PRIVACY OFFICIAL

The Plan has designated that it is a group health plan within the meaning of the HIPAA Privacy Rule. The Plan designates the Human Resources Director, as the Privacy Official, to take all actions required to be taken by the Plan in connection with the Privacy Rule.

### B. REQUIRED CERTIFICATION OF COMPLIANCE BY EMPLOYER

Except as provided below with respect to the Plan's disclosure of summary health information the Plan will (a) disclose PHI to the Employer or (b) provide for or permit the disclosure of PHI to the Employer by a Business Associates, Subcontractor or other plan vendor with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Employer) that:

1. The Plan has been amended to established the permitted and required uses and disclosures of such information by the Employer, consistent with the HIPAA Privacy Rule;
2. The Plan has been amended to incorporate the Plan provisions set forth in this Amendment; and
3. The Employer agrees to comply with the Plan provisions as modified by this Amendment.

### C. PERMITTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

1. The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by the HIPAA Privacy Rule. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and healthcare operations.
2. The Plan, and any Business Associate acting on behalf of the Plan, will disclose PHI to the Employer only to permit the Employer to carry out plan administration functions. Such disclosures will be consistent with the provisions of this Amendment.
3. All disclosures of PHI by the Plan or the Plan's Business Associate will comply with the restrictions and requirements set forth in this Amendment and the HIPAA Privacy Rule.
4. The Plan, and any Business Associate acting on behalf of the Plan, may not disclose, and may not permit the disclosure of, PHI to the Employer for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

**D. THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY**

The Plan will disclose PHI when required by law, and when permitted by an authorization from the individual to which the PHI relates, but only to the extent allowed under the authorization.

**E. DISCLOSURE OF PHI BY EMPLOYER**

The Employer agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan or as permitted or required by the HIPAA Privacy Rule;
- Ensure that any agents, including Business Associates or Subcontractors, to whom the Employer provides PHI received from the Plan, or whom creates PHI on behalf of the Plan, agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for in the Plan (as amended) and in the HIPAA Privacy Rule of which it becomes aware;
- Make PHI available to an individual in accordance with the HIPAA Privacy Rule's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with the HIPAA Privacy Rule;
- Make and maintain an accounting so that it can make available those disclosures of PHI that it must account for in accordance with the HIPAA Privacy Rule;
- Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of U.S. Department of Health and Human Services for the purposes of determining the Plan's compliance with the HIPAA Privacy Rule;
- If feasible, return or destroy all PHI received from the Plan, or the Business Associate or the Subcontractor on behalf of the Plan, that the Employer still maintains in any form, and retain no copies of such PHI after such PHI is no longer needed for the purpose for which disclosure was made. If, however, such returned or destruction is not feasible, the Employer will limit further

uses or disclosure of the PHI to those purposes that make the return or destruction of the PHI infeasible;

- The Employer will ensure that the required adequate separation, as provided in this Amendment, is established and maintained.

**F. ADEQUATE SEPARATION BETWEEN THE PLAN AND THE EMPLOYER**

In accordance with HIPAA Privacy Rule, only the following employee(s) or classes of employees may be given access to PHI to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule:

- Human Resources Director

**G. LIMITATIONS OF PHI ACCESS AND DISCLOSURE**

The persons described in section F may only have access to and use and disclose of PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer performs for the Plan. These individuals will have access to PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of PHI in violation of, or noncompliance with, the provisions of this Amendment or the HIPAA Privacy Rule.

**H. REPORT OF VIOLATION OR NONCOMPLIANCE**

The Employer will promptly report any violation or noncompliance described in section G to the Plan and will cooperate with the Plan to correct the violation or noncompliance to impose appropriate disciplinary action and/or sanctions, and to mitigate any harmful effect of the violation or noncompliance.

## HIPAA SECURITY PRACTICES

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

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:

- 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;
- 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;
- 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 Security Measures to protect the Electronic PHI; and

- Report to the Plan any Security Incident of which it becomes aware.

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

## RIGHTS UNDER USERRA

If you are absent from employment because you are in the uniformed service, you may elect to continue your coverage under this Plan for up to 24 months. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's Open Enrollment Period, and pay your contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your Dependents' coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA. Contact your Employer for information concerning your eligibility for USERRA and any requirements of the Plan.

"Uniformed Services" means 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.

## RIGHTS UNDER FMLA

The Plan will at all times comply with FMLA. During any leave taken under FMLA, an Employee may maintain coverage under this Plan on the same conditions as if he or she had been continuously employed during the entire leave period. To continue coverage during FMLA, the Employee must comply with the terms of the Plan, including election during the Plan's annual Open Enrollment Period, and pay any required contributions. Contact the Employer for information concerning eligibility for FMLA and any requirements of the Plan.

## YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D CREDITABLE COVERAGE – PLANS A & B.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Kingsville Employee Benefit Plan Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage

Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Kingsville has determined that the prescription drug coverage offered by the City of Kingsville Employee Benefit Plan Trust is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Kingsville Employee Benefit Plan Trust coverage will be affected. The City of Kingsville Employee Benefit Plan Trust provides prescription coverage for certain covered medications. The prescription coverage for Plans A & B has a co-pay of $5.00 for generic prescriptions and a co-pay of 25% for brand name prescriptions. Further details of your prescription coverage can be found in your Summary Plan Description.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and drop your City of Kingsville Employee Benefit Plan Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop your current prescription drug coverage with City of Kingsville Employee Benefit Plan Trust and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

When you make your decision, you should also compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Contact our office for further information or call your Claims Administrator, Entrust, Inc. at 281-368-7878, Attn. Customer Service. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Kingsville Employee Benefit Plan Trust changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.
For more information about Medicare drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

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|---|---|
| Date: | October 1, 2012 |
| Name of Entity/Sender: | City of Kingsville |
| Contact--Position/Office: | Entrust, Inc. |
| Address: | P O Box 441588, Houston, TX 77244-1588 |
| Phone Number: | (281) 368-7878 Attn: Customer Service |

# APPENDIX A - GENERAL PLAN INFORMATION

**TYPE OF ADMINISTRATION**

The Plan is a self-funded welfare plan and the administration is provided through a third party Claims Administrator.

The funding for the benefits is derived from the funds of the Employer (and contributions made by covered Employees). The Plan is not insured.

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|---|---|
| **PLAN NAME:** | City of Kingsville Employee Benefit Plan Trust |
| **GROUP NUMBER:** | 566000 |
| **TRUST ID NUMBER:** | 74-3018584 |
| **TAX ID NUMBER:** | 74-6001513 |
| **PLAN EFFECTIVE DATE:**<br>**AMENDED & RESTATED EFFECTIVE DATE:**<br>**RESTATED:** | October 1, 2001<br>October 1, 2011<br>June 1, 2012 |
| **PLAN YEAR:** | October 1 - September 30 |
| **EMPLOYER (PLAN SPONSOR) INFORMATION:** | City of Kingsville<br>P.O. Box 1458<br>Kingsville, Texas 78363 |
| **TRUSTEE(S):** | Vincent J. Capell<br>(Same address as Plan Sponsor) |
| **AGENT FOR SERVICE OF LEGAL PROCESS:** | See Trustee(s) |
| **CLAIMS / CONTRACT ADMINISTRATOR:** | Entrust, Inc.<br>P. O. Box 441588<br>Houston, Texas 77244-1588<br>(281) 368-7878 |

**PREFERRED PROVIDER ORGANIZATION (PPO)**

CHRISTUS SPOHN Health System
1702 Santa Fe
Corpus Christi, TX 78404
Phone # (361) 881-3280
Fax # (361) 881-3103
www.christusspohn.org

First Health Network
3200 Highland Avenue
Downers Grove, Illinois 60515
Tel. (800) 226-5116
www.myfirsthealth.com