

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

FOR

COUNTY OF DAKOTA COUNTY

EMPLOYEE HEALTH BENEFIT PLAN

G - 30071373

**REVISED AND RESTATED:
JANUARY 1, 2018**

County of Dakota County hereby amends and restates its self-funded health care plan for the benefit of eligible Employees and their eligible Dependents.

The purpose of the County of Dakota County Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the Company's eligible Employees and their eligible Dependents.

The Company caused this instrument to be executed by its duly authorized officers effective as of the 1st day of January 2018.

COUNTY OF DAKOTA COUNTY

By: _____

Title: _____

Date: _____

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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or Accident. The medical benefits available under the County of Dakota County Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the Company has attempted to provide the best coverage possible within the financial limits of both the Company and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the Company.

The Company has selected **Delphi**, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact **Delphi** at **(888) 289-0700** at least 72 hours prior to any scheduled admission for a medical condition, Mental or Nervous Disorder, Substance Abuse/Substance Dependence treatment, or Outpatient Surgical Procedures. In case of an emergency Hospital admission or emergency surgery, **Delphi** must be notified within two working days following admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the **Delphi** pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the Company incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources[®], for assistance. Group Resources is always available to assist you with your questions. We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our Company.

County of Dakota County

PRIVACY AND SECURITY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY AND SECURITY OF MEDICAL INFORMATION" shall also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Privacy and Security of Medical Information

Family Members, Relatives, Close Personal Friends. The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

Business Associates. The Plan contracts with individuals and entities (“business associates”) to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan’s financial records. The Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out legal responsibilities of the Business Associate or for data aggregation services relating to the health care operations of the Plan. The Business Associate may disclose PHI in connection with a function, service or responsibility or service to be performed by the Business Associate and such disclosure is: required by law; or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential, and used or further disclosed only as required by law or for the purposes for which it was disclosed, and the person agrees to notify the Business Associate of any breaches of confidentiality.

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers’ Compensation. The Plan may release your medical information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;

Privacy and Security of Medical Information

- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Privacy and Security of Medical Information

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

DISCLOSURES TO THE COMPANY. The Plan will disclose your medical information to the Company for Plan administration purposes only upon receipt of a certification from the Company that the Plan sets forth the permitted uses and disclosures of medical information by the Company on behalf of the Plan, and that the Company has agreed to the following assurances:

- The Company will not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
- The Company will ensure that any agents, including subcontractors, to whom it provides medical information (including electronic medical information) received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information and agree to implement reasonable and appropriate security measures to protect the information;
- The Company will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Company will not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- The Company will report to the Plan any use or disclosure of medical information that is inconsistent with the permitted uses and disclosures, of which it becomes aware;
- The Company will report to the Plan, within a reasonable time after the Company becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic medical information;
- The Company will report to the Plan any other security incident on an aggregate basis every quarter or more frequently upon the Plan's request;
- The Company will make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
- The Company will, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The Company will ensure that there is adequate separation between the Plan and the Company (as described below) and that the separation is supported by reasonable and appropriate security measures;

Privacy and Security of Medical Information

- The Company will make your medical information available to you (as described below);
- The Company will make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The Company will make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

If the Plan uses or maintains an electronic health record with respect to your medical information, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to another entity or person.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator, as provided for in 45 C.F.R §164.528 of the HIPAA requirements.

Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Privacy and Security of Medical Information

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COMPANY. Only Employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, *you* may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

VENDOR LISTING

Plan Administrator

County of Dakota County
1601 Broadway
Dakota City, NE 68731
(402) 987-2126

Administrative Service Agent

Group Resources
3080 Premier Parkway, Suite 100
Duluth, GA 30097
(800) 749-9963

Pre-Certification Administrator

Delphi
(888) 289-0700

Prescription Drug Program

Welldyne
(888) 886-5822
www.welldynrx.com

Preferred Provider Organization (PPO)

Midlands Choice
(800) 605-8259
www.midlandschoice.com

PHCS
(800) 256-3730
www.multiplan.com

MEDICAL BENEFITS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below.

This Plan treats Mental or Nervous Disorders as any other Illness. For benefits, please check below for the Provider who is performing the services. Substance Abuse/Substance Dependence is not covered.

CALENDAR YEAR DEDUCTIBLE

PPO

Single.....	\$400
Family	\$800

NON-PPO

Single.....	\$1,600
Family	\$3,200

Eligible expenses are applied to either the PPO or Non-PPO Deductible. The two Deductibles are completely separate.

CARRY OVER DEDUCTIBLE Applies
Charges incurred in October, November, or December of a Calendar Year and applied to the Deductible for that Calendar Year will also apply to the Deductible for the following Calendar Year.

COMMON ACCIDENT DEDUCTIBLE Applies
This provision applies when two or more Covered Persons 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.

COINSURANCE (After satisfaction of the Calendar Year Deductible)

PPO	80%
NON-PPO	60%

If a Covered Person is living outside of the PPO network, traveling for business or pleasure outside of the PPO network, or if charges are incurred for treatment of a Medical Emergency (see "DEFINITIONS") which occurs outside of the PPO network, benefits will be processed at the PPO Coinsurance rate subject to the PPO Deductible, PPO Out-of-Pocket, or PPO Copay if the Covered Person utilizes a Multiplan/PHCS PPO Provider/facility.

OUT-OF-POCKET MAXIMUM

PPO

Single.....	\$1,200
Family	\$2,400

NON-PPO

Single.....	\$3,200
Family	\$6,400

The Out-of-Pocket Maximum includes medical Copays.

Medical Benefits

Eligible expenses are applied to either the PPO or Non-PPO Out-of-Pocket. The two Out-of-Pockets are completely separate. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, the Calendar Year Deductible, penalties and non-covered charges do not apply to the Out-of-Pocket Maximum.

AMBULANCE SERVICES

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS Unlimited

CARDIAC REHABILITATION (Letter of Medical Necessity is required)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

CHEMOTHERAPY/RADIATION

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

CHIROPRACTIC CARE (See Spinal Manipulation)

CURAQUICK (Hy-Vee stores only - Deductible waived) \$15 Copay per visit, then 100%

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility - includes professional fees incurred for automated tests)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

DURABLE MEDICAL EQUIPMENT (Letter of Medical Necessity is required)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

EMERGENCY ROOM SERVICES

PPO (Deductible waived)..... \$150 Copay per visit, then 100%
NON-PPO (Deductible waived) \$150 Copay per visit, then 100%

HOME HEALTH CARE (Letter of Medical Necessity is required)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%
Maximum Visits Per Calendar Year..... 100 visits

HOSPICE CARE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum	180 days per occurrence or 360 days lifetime

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a \$500 penalty will apply)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

- a) for a semi-private room, the average semi-private room rate of the Hospital;
- b) for a private room, the average semi-private room rate of the Hospital, or if the Hospital has private rooms only, the maximum eligible charge will be limited to 95% of the actual private room charge;
- c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

PPO	\$30 Copay, then 100% for initial visit, additional visits are subject to Deductible and 80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT SURGERY (Hospital, Outpatient Surgical Center – must be pre-certified or a \$500 penalty will apply)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

PHYSICAL THERAPY (Letter of Medical Necessity is required – benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition within two months of the start of treatment.)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60% up to a maximum of \$20 per visit
Maximum Visits Per Calendar Year	24 visits

PHYSICIAN'S SERVICES

Office Visit (Includes Copay includes visit charge, injections, lab, and x-ray)

PPO (Deductible waived)	\$30 Copay per visit, then 100%
NON-PPO (Deductible applies)	60%

Medical Benefits

Office Surgery

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies) 60%

All Other Services (Services rendered outside of the Physician's office)

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies) 60%

PULMONARY REHABILITATION (Letter of Medical Necessity is required)

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies)..... 60%

RENAL/PERITONEAL DIALYSIS

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies)..... 60%

SECOND SURGICAL OPINION

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies)..... 60%

SKILLED NURSING FACILITY CARE (Letter of Medical Necessity is required)

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies)..... 60%

Maximum Days Per Calendar Year..... 100 days

SPEECH/OCCUPATIONAL THERAPY (Letter of Medical Necessity is required – benefits are available only for rehabilitation services that are expected to result in significant physical improvement in the condition within two months of the start of treatment. Speech Therapy is only covered for Injury, Illness, or congenital anomaly.)

PPO (Deductible applies)..... 80%

NON-PPO (Deductible applies)..... 60%

SPINAL MANIPULATION TREATMENT

PPO (Deductible waived)..... **\$30** Copay per visit, then 100%

NON-PPO (Deductible applies)..... 60%

Maximum Visits Per Calendar Year..... 24 visits

URGENT CARE FACILITY

PPO (Deductible waived)..... **\$30** Copay per visit, then 100%

NON-PPO (Deductible applies)..... 60%

WELLNESS EXPENSE

Colonoscopy

PPO (Deductible waived)	100%
NON-PPO	Not Covered

All Other Services

PPO (Deductible waived)	100%
NON-PPO (Deductible applies)	60%

Preventive services are covered with no cost share if a PPO Provider is used. This benefit includes, but is not limited to: routine physical/exam; gynecological exam; mammogram; pap smear; prostate testing (PSA); other routine lab and x-ray; immunizations; routine endoscopy, colonoscopy or sigmoidoscopy; and vision and hearing screening for children. Many of these services are covered only for specific age groups. For more detailed information on covered preventive services, please visit these websites:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, available at <https://www.uspreventiveservicestaskforce.org/page/name/uspstf-a-and-b-recommendations>;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved, available at <http://www.cdc.gov/vaccines/acip/index.html>;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, available at <http://www.hrsa.gov/>; and
- With respect to women, preventive care and screening provided by the Health Resources and Services Administration, available at <http://www.hrsa.gov/> and the expanded women’s preventive services, available at <http://www.hrsa.gov/womensguidelines/>. The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be the most current other than those issued in or around November, 2009.

No benefits will be paid for routine exams and related services when rendered solely for purposes of employment, participation in school athletic programs, foreign travel, immigration, the purchase of additional insurance, to obtain or maintain a license of any type, medical research, judicial or administrative proceedings or orders, or marriage or adoption.

WIGS (After chemotherapy and/or radiation)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	\$500

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM

OUT-OF-POCKET MAXIMUM FOR PRESCRIPTION DRUGS

Single	\$5,750
Family	\$11,500

Provisions of the Affordable Care Act require that all non-grandfathered health plans provide coverage for FDA approved contraceptives at no cost share for generic form; however, Non-Preferred/Preferred contraceptives will have a Copay as long as a generic form is available. For a list of covered preventive services, please visit <https://www.healthcare.gov/coverage/preventive-care-benefits/>.

WELLDYNERX PRESCRIPTION DRUG PROGRAM. WellDyneRx is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the WellDyneRx prescription drug program in two ways. Short-term prescriptions may be filled at local WellDyneRx Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. WellDyneRx home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local WellDyneRx pharmacy, and another which can be mailed to the WellDyneRx home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Generic	\$10
Preferred	\$25
Non-Preferred	\$45
Certain Over-the-Counter Drugs	\$5

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Generic	\$20
Preferred	\$50
Non-Preferred	\$90

Prescriptions not purchased through the mail order or drug card program will not be covered under this Plan. The per prescription Copay is not eligible for reimbursement under the Plan.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Some drug expenses which are not covered:

- * Drugs which can be obtained without a Physician's prescription, except for certain over-the-counter drugs such as: Claritin, Alavert, Loratidine, Prilosec, Pepcid AC, Zantac, Tagamet HP, and Axid AR;
- * Charges for the administration or injection of any drug;
- * Non-legend drugs;
- * Therapeutic devices or appliances, including hypodermic needles, syringes (except the insulin syringes and needles), support garments, and other non-medical substances, regardless of intended use;
- * Prescriptions that an eligible person is entitled to receive without charge from any worker's compensation laws, or any municipal, state or federal program;
- * Drugs labeled "caution – limited by federal law to investigational use," or an experimental drug, even though a charge is made to the eligible person;
- * Immunization agents, biological sera, blood or blood plasma, and blood derivatives;
- * Medication which is to be taken by or administered to an eligible person, in whole or in part, while the eligible person is a patient in a licensed hospital;
- * A prescription filled or refilled in excess of the number specified by the physician;
- * Any refill dispensed after one year from the Physician's original prescription order;
- * Drug charges, which are equal to or less than the Copay amount;
- * Any service or supply excluded under "EXCLUSIONS AND LIMITATIONS;"
- * DESI drugs other than those specifically listed. DESI drugs are those drugs that the FDA has determined to be ineffective;
- * Retrovir (Zidovudine, AZT, Azidothymidine) and any future AIDS specific drugs (unless prior approval is obtained through the Plan Administrator);
- * Infertility medication;
- * Growth hormones;
- * Anti-obesity drugs (appetite suppressants);
- * Retin A and Ritalin, except for children through age 18;
- * Accutane, Avonex, Adderal (unless prior approval is obtained through the Plan Administrator);
- * Injectable drugs, other than insulin, insulin syringes/needles;
- * Viagra;
- * Propecia and other hair growth stimulants; and
- * Medications to treat conditions excluded elsewhere.

This is not a complete list of drugs that are excluded. To determine specific drug coverage, please contact WellDyneRx at (888) 886-5822 or www.welldynrx.com.

DENTAL BENEFITS

Benefits are payable only if the covered dental expenses are for treatment that is:

- 1) Incurred and completed while dental coverage is in effect; and
- 2) Provided by:
 - A licensed Dentist;
 - A licensed Doctor; or
 - A dental assistant or a Dental Hygienist working under the direct supervision of a Dentist;and
- 3) Provided according to generally accepted dental practice; and
- 4) Necessary for the diagnosis, prevention or correction of dental disease, defect or Accidental Injury.

CALENDAR YEAR DEDUCTIBLE PER PERSON

Single.....	\$25
Family	\$75

CALENDAR YEAR MAXIMUM BENEFIT PER PERSON (Excluding orthodontia) \$1,250

LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIA

(Coverage for Covered Persons age 8 to 19) \$1,000

Percent of Covered Charges Payable

CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES (Deductible waived)..... 100%

CLASS II-BASIC PROCEDURES (Deductible applies)..... 80%

CLASS III-MAJOR PROCEDURES (Deductible applies)..... 50%

CLASS IV-ORTHODONTIA (Deductible applies)..... 50%

CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES

- One routine oral exam each six month period
- One prophylaxis (cleaning) each six month period
- One set of bitewings each 12 month period
- A complete series each three year period unless special need is shown
- Topical application of fluoride for dependent children under age 19 once each 12 month period
- Space maintainers for dependent children under age 19
- Oral hygiene instruction, but not more than once per lifetime

CLASS II – BASIC PROCEDURES

- Emergency treatment for pain
- Fillings (amalgam, synthetic porcelain, and plastic)
- Stainless steel crowns

- Sealants for dependent children age 15 and under once per tooth per lifetime
- Oral surgery
 - Tooth extractions and other oral surgery, including pre and post operative care, alveoloplasty, vestibuloplasty, removal of cysts, tumors, growths, neoplasms, and retreatment of simple compound fractures
- Periodontics
 - Non-surgical: procedures necessary for the treatment of diseases of the gums. Coverage is limited to one non-surgical periodontal treatment per quadrant every 24 months; and
 - Surgical: surgical procedures necessary for the treatment of diseases of the gums and bone supporting the teeth. Coverage is limited to one treatment per quadrant every 36 months
- Endodontics
 - Pulpotomies on primary teeth for Dependent children and root canal therapy – no coverage is provided for retreatment)

CLASS III - MAJOR PROCEDURES

- Crowns, inlays, and onlays
- Gold fillings when other filling materials cannot be used
 - Replacement of a crown, inlay, or onlay will be provided only after a five year period measured from the date on which the procedure was last covered by the Plan
- Bridges, partial dentures, and complete dentures
 - Benefit for the replacement of prosthetics will be provide only after five years have elapsed from when last covered and then only in the event that the existing appliance is not and cannot be, made satisfactory. Coverage is not provided for replacement of an existing partial denture with a bridge

CLASS IV - ORTHODONTIA

This is treatment to move teeth by means of appliances, to correct a handicapping malocclusion of the mouth. Services include preliminary study and treatment plan, x-rays, diagnostic casts, active treatment and retention appliance. Payments for comprehensive full-banded orthodontic treatments are made in installments.

ALTERNATE TREATMENT. Many dental conditions can be treated in more than one way. This Plan has an “alternate treatment” clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefits payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

RECONSTRUCTIVE SURGERY. Benefits will be provided for reconstructive surgery when such dental procedure is incidental to or follows surgery resulting from Injury, Illness, or other diseases of the involved part, when such dental procedure is performed on a covered Dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending Physician, provided that such procedures are dental reconstructive surgical procedures.

COVERED CHARGES. Covered Charges will be the actual cost charged for the treatment or service for a dental condition, but not more than the Reasonable Charge or Customary Charge.

If it is determined that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the least expensive of the procedures that would provide professionally acceptable results.

BEGINNING DATE FOR TREATMENT OR SERVICE. Treatment or service will be considered to begin:

- 1) For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
- 2) For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
- 3) For full or partial dentures, on the date the master impression is made; or
- 4) For all other services, on the date the treatment or service is performed.

LIMITATIONS AND EXCLUSIONS. Dental benefits will not be paid for:

- 1) Treatment or service that is covered by a workers' compensation or occupational disease or similar law;
- 2) Treatment or service for which the Covered Person has no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States government or one of its agencies;
- 3) Cosmetic dental work;
- 4) Services of Anesthesiologists;
- 5) Services which are not included in "DENTAL BENEFITS";
- 6) Dental procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting, and gnathologic recording;
- 7) Direct diagnostic, surgical or non-surgical treatment procedures applied to body joints or muscles,; except as provided under orthodontics;
- 8) Implants (artificial materials implanted or grafted into or onto bone or soft tissue) or surgical removal of implants;
- 9) Veneers (bonding of coverings to teeth);
- 10) Consultations and office visits;
- 11) Temporary procedures;
- 12) Athletic mouth guards, splints or occlusal guards;
- 13) Re-treatment or additional treatment necessary to correct or relieve the results of previous treatment;
- 14) Removable unilateral dentures;
- 15) Crown lengthening;

- 16) Procedures performed by other than licensed Dentist or his/her employees or agents; and
- 17) Repair or replacement of any orthodontic appliance (fixed or removable).

DEFINITIONS

As used in this Plan, the following words and phrases shall have the meanings indicated:

ACCIDENT means an incident resulting in Injury that occurs from external forces under unexpected circumstances, and which is in no way the fault of the victim. Injuries to teeth resulting from chewing or biting; as well as sprains and strains resulting from overexertion, excessive use, or overstretching will not be considered Accidental Injuries for purposes of medical benefit determination.

ADMINISTRATIVE SERVICE AGENT means the firm providing administrative services to the Plan Administrator in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Plan Administrator with any other information deemed necessary. Group Resources is the Administrative Services Agent for the Plan.

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS means the maximum amount that can be paid on behalf of a Covered Person during the period of time beginning on March 1 and ending on February 28 or 29 of the following year.

APPROVED CLINICAL TRIAL is defined in the statute as a phase i, phase ii, phase iii, or phase iv clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- 1) a federally funded or approved trial;
- 2) a clinical trial conducted under an FDA investigational new drug application; or
- 3) a drug trial that is exempt from the requirement of an FDA investigational new drug application.

CALENDAR YEAR means each period of time beginning on January 1 and ending on December 31 of the same year.

COINSURANCE means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

COMPANY means County of Dakota County or any affiliate which is participating in the Plan with the permission of County of Dakota County.

COSMETIC TREATMENT means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

COVERED PERSON means an Employee or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

CUSTOMARY CHARGE means a charge for medical services, care, or supplies that does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

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

The term “same geographic locale” means a city, county, or such greater area as may be necessary to establish a representative cross section of persons or organizations regularly furnishing the type of treatment, services, or supplies for which a specific charge is made.

The term “Customary” does not necessarily mean the actual charge made or the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, or hospital. The Plan will determine what the usual charge is, for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Customary Charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer’s retail pricing (MRP) for supplies and devices.

DEDUCTIBLE means the amount of eligible charges that a Covered Person must incur before benefits will be payable, as listed in “MEDICAL BENEFITS” and “DENTAL BENEFITS.” The Covered Person must meet a new Deductible each Calendar Year. The Deductible will be applied separately to each Covered Person except when the family Deductible (shown in “MEDICAL BENEFITS” and “DENTAL BENEFITS”) has been met by the family. Once the family Deductible is met, no further Deductible for any Covered Person in that family will be required during that Calendar Year.

DENTAL HYGIENIST means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

DENTAL TREATMENT PLAN means the Dentist's report of proposed treatment which:

- 1) lists the procedures required for the Period of Dental Treatment; and
- 2) shows the charges for each procedure; and
- 3) is accompanied by any diagnostic materials that might be required.

DENTIST means:

- 1) a person licensed to practice dentistry; and
- 2) a licensed Physician who provides dental treatment or service.

DEPENDENT means a person who meets one of the following requirements:

- 1) is the Employee's spouse who resides in the United States (unless the spouse is legally separated or divorced from the Employee); or
- 2) is the Employee's:
 - a) child less than 26 years of age; or
 - b) unmarried child age 26 or older meeting all of the following conditions:

- i) subject to a physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
- ii) is unable to engage in any substantial gainful activity due to such physical or mental impairment; and
- iii) for whom proof of such physical or mental impairment is submitted to the Plan Administrator within 30 days of the date coverage would have ended as a result of the child's age.

The term "spouse" refers to an individual of the same or opposite sex, who is lawfully married to the Covered Person under the laws of the state in which the marriage occurred.

The term "child" includes a natural child, an adopted child at time of placement, a child for whom the Employee or Employee's spouse is Legal Guardian, and a stepchild.

Notwithstanding the above, the term "child" also includes a child of the Covered Person whose coverage is ordered under a qualified medical child support order (QMCSO).

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

In the case of an individual whose parents are divorced, the individual may be considered the "child" of either parent.

The term "Dependent" does not include a legally separated or divorced spouse of the Employee, any person who is covered under the Plan as an Employee, any person serving in the armed forces of any country; unless such a person is the child of the covered Employee who has not attained age 26, or other individuals living in the covered Employee's home who are not eligible as defined. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

DURABLE MEDICAL EQUIPMENT means equipment which is:

- 1) able to withstand repeated use;
- 2) primarily and customarily used to serve a medical purpose; and
- 3) not generally used by a person in the absence of Illness or Injury.

EMPLOYEE means any person employed on a regular basis by the Company in the conduct of the Company's regular business, who is regularly scheduled to work at least 30 hours per week, and who is classified by the Company, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan.

The term "Employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

ESSENTIAL HEALTH BENEFITS, includes, in addition to any other services that are required to be treated as "Essential Health Benefits" under the Patient Protection and Affordable Care Act of 2010, the following general categories and items and services covered within the categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

HOME HEALTH CARE means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:

- 1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
- 2) Occupational Therapy, Speech Therapy, and Physical Therapy which are provided by a Home Health Care Agency;
- 3) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.

The term "Home Health Care" does not include:

- 1) services or supplies not included in the Home Health Care plan;
- 2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;
- 3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
- 4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
- 5) transportation.

HOSPICE means a public agency or private organization which meets all of the following requirements:

- 1) is primarily engaged in providing care to terminally ill patients;
- 2) provides 24-hour care to control the symptoms associated with terminal illness;
- 3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
- 4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
- 5) maintains central clinical records on all patients;
- 6) provides appropriate methods of dispensing drugs and medicines; and
- 7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:

- 1) custodial care;
- 2) care for drug addicts and alcoholics; or
- 3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:

- 1) a place of rest;
- 2) a place for the aged; or
- 3) a hotel or similar institution.

HOSPITAL means a place which meets all of the following requirements:

- 1) is accredited as a general hospital by the Joint Commission on Accreditation of Hospitals or is accredited by The Commission on Accreditation of Rehabilitation Facilities (CARF);
- 2) is open at all times;
- 3) is operated chiefly for the treatment of sick or injured persons as Inpatients;
- 4) has a staff of one or more Physicians available at all times;
- 5) provides 24 hour nursing services by Registered Nurses (R.N.s);
- 6) includes areas designed for diagnosis and major Surgical Procedures.

The term "Hospital" also includes:

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

The term "Hospital" does not include a convalescent facility, nursing home, rest home, Skilled Nursing Facility or a facility chiefly operated for treatment of the aged.

ILLNESS means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

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

INJURY means bodily Injury caused by an Accident and which results directly from the Accident and independently of all other causes.

INPATIENT means an individual confined as a registered bed patient in a Hospital, Skilled Nursing Facility or Hospice.

LEGAL GUARDIAN means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LIFETIME means the maximum benefit while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

MAXIMUM BENEFIT means the maximum amount payable for the period indicated for a Covered Person for all eligible charges incurred while covered under the Plan.

MEDICAL EMERGENCY means a sudden and unexpected onset of a medical condition requiring medical care which the patient secures immediately after the onset and, as a general rule, is a condition which would be life threatening or would cause serious impairment if immediate care were not received.

MEDICALLY NECESSARY means health care services, supplies, or treatments which are for the purpose of evaluation, diagnosis, or treatment of the Covered Person's Injury or Illness and are:

- 1) recommended, approved, or ordered by a Physician or Dentist exercising prudent clinical judgment, and clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the Covered Person's Illness or Injury;
- 2) consistent with the patient's condition or accepted standards of good medical and dental practice;
- 3) not performed for the convenience of the patient or the Provider of medical and dental services;
- 4) no more costly than alternative interventions, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical conditions;
- 5) not conducted for research purposes; and
- 6) the most appropriate setting and level of services which can be safely provided to the Covered Person, considering the Covered Person's medical symptoms and conditions.

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

In addition, with respect to Mental or Nervous Disorders, Substance Abuse, and Substance Dependence, to be considered "Medically Necessary," the treatment, services, and/or supplies must not be (a) maintenance therapy or maintenance treatment, or (b) a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

MENTAL OR NERVOUS DISORDER: To be a Mental Disorder or Nervous Disorder, the disease or condition, regardless of whether the cause is organic, must be classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Mental or Nervous Disorder does not include Substance Abuse or Substance Dependence or any condition resulting therefrom.

MORBID OBESITY means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

OCCUPATIONAL THERAPY means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

OUT-OF-POCKET MAXIMUM means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not include the Deductible amount on this plan, non-covered items and penalties.

OUTPATIENT means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

OUTPATIENT SURGICAL CENTER means any public or private establishment which:

- 1) has a staff of Physicians;
- 2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
- 3) provides continuous Physician and nursing services while patients are in the facility.

PERIOD OF DENTAL TREATMENT means all sessions of dental care that result from the same initial diagnosis and any related complications.

PHYSICAL THERAPY means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

PHYSICIAN means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), a Doctor of Podiatry (D.P.M.), a Doctor of Chiropractic (D.C.), an Audiologist, a Certified Registered Nurse Anesthetist (C.R.N.A.), a Licensed Physical Therapist (L.P.T.), a Midwife, an Occupational Therapist, an Optometrist (O.D.), a Physiotherapist, a Psychiatrist, a Psychologist (Ph.D.), a Speech and Language Pathologist, a Licensed Clinical Social Worker (L.C.S.W.), a Master of Social Work (M.S.W.), a Licensed Professional Counselor (L.P.C.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency, and who is acting within the scope of his or her license, to the extent that his or her services are covered under this Plan.

The term "Physician" does not include a person who:

- 1) is the Covered Person receiving treatment; or
- 2) is a relative by blood or marriage of the Covered Person receiving treatment.

PRE-ADMISSION TESTING means x-ray and laboratory examinations which:

- 1) are performed on an Outpatient basis;
- 2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
- 3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

PREFERRED PROVIDER ORGANIZATION (PPO) means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided. Utilization of PPO network Providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the Providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at www.midlandschoice.com or www.multipplan.com.

PROVIDER means a Hospital, Physician, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as a covered expense in the Plan.

REASONABLE CHARGE means fee(s) for services or supplies which are Medically Necessary for the care and treatment of Illness or Injury not caused by the treating provider. When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered the "Reasonable Charge" for the treatment. The determination of whether a charge is a Reasonable Charge will consider, but will not be limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable.

ROOM AND BOARD means the Hospital's charge for:

- 1) room and linen service;
- 2) dietary service, including meals, special diets, and nourishments; and
- 3) general nursing service.

SECOND SURGICAL OPINION means charges incurred on an Outpatient basis for Physician's fees, and related diagnostic tests to confirm that surgery is Medically Necessary. The Physician who provides the Second Surgical Opinion must be one who:

- 1) treats the type of condition for which surgery is advised;
- 2) is not scheduled to do the surgery; and
- 3) has no business or financial relationship with the Physician recommending or performing the surgery.

If the second Physician disagrees with the first Physician, benefits will be payable for the cost of a third opinion subject to the conditions listed above.

SKILLED NURSING CARE means those charges incurred for:

- 1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
- 2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:

- 1) that part or all of any nursing care that does not require the skills of an R.N.; or
- 2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

- 1) is licensed according to state or local laws;
- 2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
- 3) includes areas for medical treatment;
- 4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
- 5) maintains daily health records for each patient;
- 6) has an agreement which provides for the services of a Physician;
- 7) has a suitable method for providing drugs and medicines to patients;
- 8) has an arrangement with one or more Hospitals for the transfer of patients;
- 9) has an effective utilization review plan;
- 10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
- 11) is not solely a place for:
 - a) rest, rehabilitation or custodial care;
 - b) the aged;

- c) the treatment of drug addiction or Substance Abuse/Substance Dependence;
- d) the treatment of alcoholism; or
- e) those who are mentally disabled or who have mental disorders.

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

SPEECH THERAPY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.

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.

SURGICAL PROCEDURE includes, but is not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME means a jaw/joint disorder causing pain, swelling, clicking, and difficulties in opening and closing the mouth; and complications including arthritis, dislocation, and bite problems of the jaw.

TOTAL DISABILITY or TOTALLY DISABLED means an Injury or Illness which:

- 1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the Company; and
- 2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and gender.

URGENT CARE FACILITY means a walk-in facility, specifically excluding a Hospital emergency room, that treats Illnesses and Injuries without a scheduled appointment. Urgent Care Facilities offer some services that are not generally available in a primary care Physician's office, and are typically used for Injuries and Illnesses that cannot wait for a traditional appointment but do not require the services of a Hospital emergency department.

WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:

- 1) for which such person is not eligible; or
- 2) in excess of the maximum amount provided under any benefit for which the person is covered.

ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES:

All Employees in an eligible class.

No benefits are provided for retired Employees or their Dependents.

REQUIRED EMPLOYEE CONTRIBUTIONS:

Employees do contribute toward the cost of Employee and Dependent coverage.

The amount that Employees contribute is calculated by the Plan Administrator and is a portion of the cost of coverage under the Plan.

ELIGIBILITY FOR EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:

- 1) the effective date of the Plan; or
- 2) the first day of the month following completion of a 30 day waiting period.

For any late enrollee, any period before the late enrollee's enrollment in the Plan is not a waiting period.

OPEN ENROLLMENT means the period from February 1 through February 28 or 29 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the Company may make changes to their coverage. Coverage under any newly elected option will take effect on March 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to March 1 of each year, the previous year's coverage will remain in effect.

Benefit choices made during the Open Enrollment period will remain in effect until the first day of the following Plan Year unless a Covered Person experiences an event that qualifies as a Special Enrollment event under the provisions of HIPAA or an event that allows the Covered Person to change their election under a Section 125 (or "cafeteria") plan. See "Pre-Tax Premium Payment" below for additional information.

SPECIAL ENROLLMENT RIGHTS. If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health insurance or group health plan coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan if the Employee or his Dependents lose eligibility for that other coverage (or if an employer stops contributing towards the Employee's or his Dependent's other coverage), provided that the Employee requests enrollment within 30 days after the other coverage ends (or within 30 days after an employer stops contributing towards the other coverage). In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

SPECIAL ENROLLMENT PERIOD. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan upon the occurrence of one of the following:

- 1) the Employee or Dependent loses other health coverage and meets the following conditions:
 - a) the individual had other health coverage at the time he became eligible for the Plan;
 - b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
 - c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will not trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
 - d) the individual makes a request for enrollment under the Plan within 30 days after losing the other coverage.

If an Employee fails to provide the written statement required under b) above, the Plan may not provide special enrollment to the Employee or any of his Dependents.

- 2) the Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request for enrollment under the Plan within 30 days of such event.
- 3) the Employee or Dependent loses coverage under Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility for Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of the loss of coverage.
- 4) the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of such event.

EFFECTIVE DATE FOR EMPLOYEE COVERAGE. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;

- b) in the case of marriage, the date of marriage, provided that special enrollment is timely requested;
 - c) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - d) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
- a) the date the Employee becomes eligible for coverage; or
 - b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 30 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE. If an Employee fails to make written application for coverage within 30 days of his initial eligibility under the Plan (or, fails to request enrollment within 30 days of the occurrence of an event which would entitle him to Special Enrollment, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

EMPLOYEES ON MILITARY LEAVE. Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage. In cases where leave is for more than 31 days, the Employee cannot be required to pay any more than 102 percent of the full premium. If the Employee performs services for less than 31 days, he or she cannot be required to pay more than the normal Employee share for such coverage. Regardless of whether extended health care coverage is elected or declined, the Employee is entitled to immediate coverage under the Plan, upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service. Plan exclusions and waiting periods may be imposed for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

REHIRED EMPLOYEES. Employees who are terminated from employment and are rehired within three months following termination will not be required to satisfy the waiting period. These Employees and their Dependents will also receive credit for any Deductible and Out-of-Pocket which was previously satisfied, as well as for any maximums which may have been all or partially met. Employees who are terminated and rehired more than three months after their termination date will not receive any type of credit for previous participation in the Plan.

ELIGIBILITY FOR DEPENDENT COVERAGE. An Employee becomes eligible for Dependent Coverage on the later of:

- 1) the date the Employee becomes eligible for coverage; or
- 2) the date the Employee first acquires a Dependent.

EFFECTIVE DATE FOR DEPENDENT COVERAGE. Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
 - b) in the case of marriage, the date of marriage, provided that special enrollment is timely requested;
 - c) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - d) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
 - a) the date the Employee becomes eligible for Dependent coverage; or
 - b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 30 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE. If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

NEWBORNS. The Employee's newborn child will be covered from the date of birth only if the newborn is properly enrolled as outlined under "Special Enrollment Period." If the enrollment for a newborn is not requested within 30 days of the date of birth, the newborn cannot be enrolled until (1) the next Open Enrollment period or (2) a Special Enrollment period.

Inpatient newborn nursery charges will be covered under the mother's Deductible and Out-of-Pocket until the mother is discharged from the Hospital. Once the mother is discharged, the newborn child must meet its own Deductible and Out-of-Pocket.

NO MULTIPLE STATUS. You may not have multiple status under the Plan (*i.e.*, you may not receive benefits under this Plan as both an Employee and as a Dependent).

PRE-TAX PREMIUM PAYMENT. Your portion of the cost of your health care coverage will be paid with pre-tax dollars, and thus, is subtracted from your gross pay before taxes are determined. By doing this, your taxable pay is reduced so you pay less in taxes. Once you have made your elections for coverage for yourself and your Dependents, you cannot change them during the Plan Year unless you experience a change in status such as:

When Coverage Begins

- 1) marriage or divorce;
- 2) birth or adoption of a child, change in child custody, or the addition of stepchildren;
- 3) death of a Dependent;
- 4) a child reaching the disqualifying age for coverage;
- 5) any significant change in health care coverage for the Employee or the Employee's spouse due to the spouse's employment;
- 6) commencement of employment by the Employee's spouse;
- 7) the Employee or the Employee's spouse switching from part-time to full-time employment or vice versa;
- 8) the beginning or end of the Employee's spouse's employer-provided insurance coverage because of a change in employment status; or
- 9) a change in the Employee's employment status that affects benefit eligibility.

Any change in your coverage election under the Plan must be consistent with the change in status.

WHEN COVERAGE ENDS

EMPLOYEE COVERAGE. An Employee's coverage will terminate on the earliest of:

- 1) the date this Plan is terminated;
- 2) the end of the period for which the last required Employee contribution for the Employee's coverage has been paid;
- 3) the last day of the calendar month on which the covered Employee ceases to be in a class eligible for coverage under the Plan; or
- 4) the last day of the calendar month on which the covered Employee's employment with the Company terminates.

Ceasing active work is deemed termination of employment unless:

- 1) the covered Employee is Totally Disabled due to Illness or Injury. In that event, coverage may be continued up to six months during the disability provided required Employee contributions, if any, are made by such covered Employee; or
- 2) the covered Employee is temporarily laid off. In that event, coverage may be continued up to 90 days following the date of lay off provided required Employee contributions, if any, are made by such covered Employee; or
- 3) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective.

A covered Employee's coverage for any specific benefit will terminate on the earlier of:

- 1) the date coverage under the Plan for such benefit ends; or
- 2) the date the covered Employee ceases to be eligible for that benefit.

Coverage under this Plan will be terminated immediately upon finding that Covered Person has committed, participated in, or is participating in the commission of, fraud against the Plan. Fraud against the Plan includes, but is not limited to:

- 1) a Covered Person furnishing or participating in furnishing fraudulent information to the Plan for the purpose of obtaining benefits under the Plan (i.e., false health-related treatment claims);
- 2) permitting improper use of his or her identification card;
- 3) use of another Covered Person's Plan identification card; or
- 4) prescription forgery, falsification, or transfer of medication.

DEPENDENT COVERAGE. Dependent coverage will cease for any Dependent on the earliest of:

- 1) the last day of the calendar month on which the covered Employee's coverage terminates;
- 2) the date this Plan is terminated;
- 3) the date Dependent coverage is discontinued under this Plan;
- 4) the last day of the calendar month on which the covered Employee ceases to be in a class eligible for Dependent coverage;
- 5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;

- 6) the date the covered Employee no longer has any Dependents; or
- 7) the last day of the calendar month on which the individual ceases to qualify as a Dependent under this Plan.

LIMITED CONTINUATION OF COVERAGE. As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan in certain limited circumstances. A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:

- 1) the covered Employee's employment is terminated (for reasons other than gross misconduct); or
- 2) the covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.

The 18 months of continuation coverage may be extended in two situations: (1) if a Covered Person is determined to be disabled, or (2) another event occurs which would cause a covered Employee's covered Dependent to lose coverage, provided certain notices are timely provided to the Plan Administrator. See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:

- 1) the covered Employee dies;
- 2) the covered Employee is divorced or legally separated;
- 3) the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- 4) a child covered under the Plan ceases to be a Dependent.

Notwithstanding the foregoing:

- If the covered Employee has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guarantee Corporation as of the date of his or her termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued until the covered Employee's death, or, in the case of his or her covered Dependents, for 24 months after the covered Employee's date of death; provided, in no event will coverage be continued under this provision later than December 31, 2013 or any later date as required under applicable law.
- If a covered Employee is a TAA-eligible individual as of the date his continuation coverage would otherwise terminate, coverage may be continued until the date the covered Employee ceases to be a TAA-eligible individual; provided, however, that in no event will coverage be continued under this provision beyond December 31, 2013, or any later date as required under applicable law.

NOTICE: GENERAL. Covered Person's Responsibility. A Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. A Covered Person must give this notice prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator.

The “COBRA Notification Form” must be sent, along with applicable documentation indicated on the form (such as a divorce decree, separation order, death certificate, birth certificate, or other documentation verifying a Dependent child’s age), to the Plan Administrator at the address listed under “PLAN INFORMATION.” When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

If a Covered Person fails to provide the Plan Administrator with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived. A Covered Person who elects COBRA coverage will have the same annual enrollment rights that apply to active employees.

Company’s Responsibility. For other qualifying events (a covered Employee’s end of employment or reduction of hours of employment, death of a covered Employee, or the covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both)), the Company will notify the Plan Administrator. When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

NOTICE: DISABILITY EXTENSION. If a Covered Person is Totally Disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or becomes disabled within 60 days of beginning COBRA coverage, all Covered Persons with respect to the disabled individual may extend the continuation coverage period an additional 11 months for up to a total of 29 months.

To extend coverage beyond the 18-month period, a Covered Person must notify the Plan Administrator of the Social Security Administration’s (“SSA’s”) determination within 60 days after the later of: (1) the date of the SSA’s determination, or (2) the date on which the qualifying event occurs under this Plan, and in all cases before the end of the 18-month period of COBRA coverage. This notice must be provided on the “COBRA Notification Form,” which can be obtained from the Plan Administrator, and must be sent, along with a copy of the SSA’s disability determination, to the Plan Administrator at the address listed under “PLAN INFORMATION.”

If a Covered Person is determined by the SSA to no longer be disabled, the Covered Person must notify the Plan Administrator of that fact within 30 days of the SSA’s determination. This notice must be provided on the “COBRA Notification Form,” which can be obtained from the Plan Administrator, and which must be sent along with a copy of the SSA’s disability determination, to the Plan Administrator at the address listed under “PLAN INFORMATION.”

Upon receipt of this notice, COBRA coverage extended beyond the maximum that would otherwise apply will be terminated on the first day of the month which is 30 days after the determination that the Covered Person is no longer disabled.

NOTICE: SECOND QUALIFYING EVENTS. If a covered Dependent experiences another qualifying event while already on COBRA coverage due to the covered Employee’s employment termination or reduction in hours, the covered Dependent may elect to extend the period of COBRA coverage for up to 36 months from the date of the employment termination or reduction in hours.

For example, assume that the covered Employee and his covered Dependents elect COBRA coverage because of the covered Employee's employment termination.

If the covered Employee dies during the first 18 months of COBRA coverage, the covered Dependents could elect to continue COBRA coverage for up to 36 months from the covered Employee's date of employment termination. A Covered Person must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator and must be sent, along with applicable documentation, to the Plan Administrator at the address listed under "PLAN INFORMATION."

ELECTION. A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage. If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. If a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will begin on the date the waiver is revoked. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person who is certified as eligible for Trade Adjustment Assistance ("TAA") elects continuation coverage during the second election period described below, continuation coverage will begin on the first day of the second election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

However, if a Covered Person fails to make an election during the 60-day election period, and is certified as TAA-eligible under the Trade Adjustment Assistance Extension Act of 2011, the TAA-eligible Covered Person may elect continuation coverage during the 60-day period that begins on the first day of the month in which the individual is certified to be eligible for TAA benefits, but only if the election is made no later than six months after the date of the TAA-related loss of coverage under the Plan (the "second election period").

COST OF CONTINUATION COVERAGE. To receive continuation coverage, the Covered Person, or any third party, must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is eligible for an extension of coverage due to disability, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (“PBGC”) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the health Coverage Tax Credit Customer contact center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

BENEFITS UNDER CONTINUATION COVERAGE. If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated Employees, their spouses, and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

PAYMENT OF CLAIMS. No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

TERMINATION. A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

- 1) the date on which the Company ceases to provide a group health plan to any Employee;
- 2) the date the Covered Person first becomes covered under any other group health plan after electing continuation coverage;
- 3) the date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- 4) the date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
- 5) the end of the applicable continuation coverage period described above.

In no case will coverage extend beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

ELIGIBLE CHARGES

BENEFITS. After a Covered Person has satisfied any applicable Deductible, eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any eligible charge will generally be equal to the percentage of the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances, the Reasonable Charges or Customary Charges as described in “MEDICAL BENEFITS.”

MAXIMUM BENEFITS. The benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum for a Covered Person shown in “MEDICAL BENEFITS.” Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the lesser of the billed amounts or the PPO allowances or, in the absence of PPO allowances, the Reasonable Charges or Customary Charges, when charges are incurred for an Illness or Injury for one or more of the following:

- 1) Room and Board and routine nursing services for each day of confinement in a Hospital;
- 2) Intensive or cardiac care Room and Board if Medically Necessary;
- 3) Medical services and supplies furnished by a Hospital;
- 4) Anesthetics and their administration by a Physician (see “DEFINITIONS”) including general and local anesthesia for endoscopic procedures;
- 5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures. When two or more Surgical Procedures occur during the same operative session, the eligible expense for all charges is as follows:
 - a) if bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the lesser of the billed amount, the Reasonable Charge, Customary Charge, or PPO allowance that is allowed for the primary procedure. 50% of the lesser of the billed amount, the Reasonable Charge, Customary Charge, or PPO allowance will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered incidental, and no benefits will be provided for such procedures;
 - b) if multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the lesser of the billed amount, the Reasonable Charge, Customary Charge, or PPO allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the lesser of the billed amount, the Reasonable Charge, Customary Charge, or PPO allowance allowed for that procedure; and
 - c) if an assistant surgeon is required, the assistant surgeon's covered charge will not exceed the lesser of the billed amount, or 50% of the surgeon's Reasonable Charge, Customary Charge, or PPO allowance;
- 6) Charges for non-physician assistants at surgery, if the assistant is certified by his or her professional association, licensed with the state where employed, is credentialed by the facility to assist with the procedure, and is performing a service that would otherwise be performed by a Physician, and is performing a procedure which, according to the National Correct Coding Initiative allows an assistant at surgery;
- 7) Services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing;

- 8) Services of a licensed physical therapist or occupational therapist;
- 9) Speech Therapy administered by a speech therapist, provided the inability to speak is the result of an Illness, Injury, or congenital defect;
- 10) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae;
- 11) X-rays, laboratory tests, and other diagnostic services which:
 - a) are performed as a result of definite symptoms of an Illness or Injury; or
 - b) reveal the need for medical treatment;
- 12) X-ray and radiation therapy, chemotherapy, and renal/peritoneal dialysis, and IV therapy such as: antibiotic therapy, steroidal therapy, pain management, hydration therapy, antiretroviral and antifungal therapy, inotropic therapy, total parenteral nutrition, and gamma globulin;
- 13) The transport of a Covered Person:
 - a) within the continental United States and Canada;
 - b) by means of a professional ambulance service;
 - c) to a Hospital for a Medical Emergency, but not returning from a Hospital;
- 14) Medical supplies as follows:
 - a) drugs and medicines (including diabetic supplies):
 - i) which are approved by the Food and Drug Administration;
 - ii) which require the written prescription of a Physician;
 - iii) which must be dispensed by a licensed pharmacist or Physician; and
 - iv) which are purchased through the "PRESCRIPTION DRUG PROGRAM;"
 - b) blood, marrow, or other fluids;
 - c) artificial limbs and eyes to replace natural limbs and eyes;
 - d) repair and adjustment of prosthetic devices, when Medically Necessary;
 - e) contact lenses or lenses for standard glasses only if required promptly after, and because of, cataract surgery;
 - f) casts, splints, trusses, braces, crutches, and surgical dressings;
 - g) rental or purchase, if less expensive, of Durable Medical Equipment including, but not limited to wheelchairs, Hospital beds, and oxygen equipment; and
 - h) replacement of orthopedic shoes and other supportive appliances once each 12 month period or if under age 19, once each six month period;
- 15) Charges for services performed in an Outpatient Surgical Center or Urgent Care Facility;
- 16) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
 - a) follows a Hospital confinement for which at least three straight days of Hospital Room and Board charges were included as eligible charges under the Plan;
 - b) begins within 14 days after the Covered Person is released from such Hospital confinement;
 - c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and
 - d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;
- 17) Second surgical opinion;
- 18) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 30 days of his birth. Routine newborn care includes:
 - a) Hospital charges for Room and Board, services, and supplies;
 - b) charges related to circumcision; and
 - c) fees from Physicians for routine Inpatient pediatric care;

- 19) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
- a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;
 - b) care received from an interdisciplinary team of professionals for Hospice and home care;
 - c) pre-bereavement counseling; and
 - d) post-bereavement counseling during the 12 months following the death of the terminally ill patient, up to a limit of six sessions;
- 20) Home Health Care provided by a Home Health Care Provider if:
- a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care Provider;
 - b) the Covered Person is Totally Disabled and is essentially confined to the home;
 - c) the Covered Person is examined by the attending Physician at least once every 60 days; and
 - d) the plan of treatment including Home Health Care is:
 - i) established in writing by the attending Physician prior to the commencement of such treatment; and
 - ii) certified by the attending Physician at least once every month;
- Eligible Home Health Care services will not include:
- a) custodial care;
 - b) meals or nutritional services;
 - c) housekeeper services;
 - d) services or supplies not specified in the Home Health Care plan;
 - e) services of a relative of the Covered Person;
 - f) services of any social worker;
 - g) transportation services;
 - h) care for tuberculosis;
 - i) care for Substance Abuse/Substance Dependence;
 - j) care for the deaf or blind; or
 - k) care for senility, mental deficiency, retardation or mental illness;
- 21) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
- a) reconstruction of the breast on which the mastectomy has been performed;
 - b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and
 - c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;
- 22) Services related to organ transplants when the Covered Person is the recipient (including charges for the organ procurement to the extent that they are not covered by the donor's insurance coverage) for the following procedures:
- a) cornea;
 - b) heart;
 - c) lung;
 - d) pancreas;
 - e) liver;
 - f) kidney;
 - g) heart/lung;
 - h) bone marrow;
 - i) kidney/pancreas; and
 - j) intestinal;

- 23) Charges for Accidental Injury to or care of mouth, teeth, gums, and alveolar processes, but only if that care is for:
 - a) treatment of fractures and traumatic dislocations of the jawbone;
 - b) cutting procedures in the oral cavity for tumors or cysts of the jawbone;
 - c) treatment of an Accidental Injury to Sound Natural Teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in an Accident. Treatment for an Accidental Injury must begin within 72 hours after the Accident and be completed within 12 months from such date; and
 - d) the removal of impacted teeth;
- 24) General anesthesia and associated Hospital/Outpatient Surgical Center charges are covered in conjunction with dental care provided to patients age seven or younger, or who are developmentally disabled, or when hospitalization is Medically Necessary;
- 25) Charges for tubal ligation and vasectomy;
- 26) Maternity expenses incurred by an Employee, spouse, or Dependent child;
- 27) Charges for treatment, services, and/or supplies for a Mental or Nervous Disorder;
- 28) Charges for services in connection with surgical treatment of morbid obesity and/or panniculectomy are covered medical expenses subject to the following conditions:
 - a) a second concurring surgical opinion is required prior to the surgical procedure, and
 - b) pre-authorization by the Administrative Service Agent is required.

Coverage is subject to the following guidelines:

- a) body weight must be more than 100 pounds over or twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person (as stated in the most recent Metropolitan Life Insurance Company tables.);
- b) a Physician must confirm the condition of Morbid Obesity existed for at least five years duration immediately prior to the date surgical treatment is sought;
- c) the Covered Person may be requested to have a psychiatric evaluation to obtain a psychiatric opinion as to stability; and
- d) non-surgical methods of weight reduction must have been attempted under a Physician's supervision for at least a three year period immediately prior to the date surgical treatment is sought.

The Administrative Service Agent, on behalf of the Plan Administrator, shall make the final determination based on the individual circumstance;

- 29) As required by Section 10103(c) of PPACA, charges incurred for routine patient costs associated with Approved Clinical Trials that meet the following guidelines:
 - a) the Approved Clinical Trial is intended to treat a Covered Person who has been diagnosed with cancer or another life-threatening disease or condition;
 - b) the Approved Clinical Trial has been peer reviewed and is approved by at least one of the following:
 - i) one of the United States National Institutes of Health;
 - ii) a cooperative group or center of the National Institutes of Health;
 - iii) a qualified nongovernmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
 - iv) the United States Food and Drug Administration pursuant to an investigational new drug exemption;
 - v) the United States Department of Defense or Veterans Affairs; or

- vi) with respect to phase II, III, and IV Approved Clinical Trials, a qualified institutional review board;
- c) the facility and personnel conducting the Approved Clinical Trial is capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise;
- d) the Covered Person meets the patient selection criteria enunciated in the study protocol for participation;
- e) the Covered Person has provided informed consent for participation in a manner that is consistent with current legal and ethical standards;
- f) the available clinical or pre-clinical data provide a reasonable expectation that the Covered Person's participation in the Approved Clinical Trial will provide a medical benefit that is commensurate with the risks of participation in the Approved Clinical Trial;
- g) the Approved Clinical Trial does not unjustifiably duplicate existing studies; and
- h) the Approved Clinical Trial must have a therapeutic intent and to some extent, must assess the effect of the intervention on the Covered Person.

Patient care services are defined as health care items or services that are furnished to a Covered Person who is enrolled in an Approved Clinical Trial, which are consistent with the Reasonable Charge and Customary Charge standard of care for someone with the Covered Person's diagnosis, are consistent with the study protocol for the Approved Clinical Trial, and would be covered if the Covered Person did not participate in the Approved Clinical Trial. Patient care services do not include the following:

- a) an FDA approved drug or device, which is paid for by the manufacturer, the distributor, or the Provider of the drug or device;
- b) non-health care services that a Covered Person may be required to receive as a result of being enrolled in an Approved Clinical Trial;
- c) costs associated with managing the research associated with the Approved Clinical Trial;
- d) costs for non-investigational treatments;
- e) any item, service, or cost that is reimbursed or otherwise furnished by the sponsor of the Approved Clinical Trial; and
- f) the costs of services which are not provided as part of the Approved Clinical Trials stated protocol or other similarly, intended guidelines.

A qualified individual is defined as an individual who is enrolled or participating in a health plan or coverage and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual

- 30) Routine services as outlined in "MEDICAL BENEFITS."

EXCLUSIONS AND LIMITATIONS

- 1) **ABORTION.** No benefits will be paid for any abortion which is not Medically Necessary to preserve the life of a mother unless a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion, or unless the pregnancy is the result of rape or incest.
- 2) **ACUPUNCTURE.** No benefits will be paid for acupuncture except as administered by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O).
- 3) **BIRTH CONTROL.** No benefits will be paid for contraceptives (devices, implants, etc.) under the medical Plan. However, charges for oral contraceptives (birth control pills) are available through the "PRESCRIPTION DRUG PROGRAM."
- 4) **BREAST SURGERY.** No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in "ELIGIBLE CHARGES." Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.
- 5) **CHELATION THERAPY.** No benefits will be paid for chelation or metallic ion therapy.
- 6) **COMPLICATIONS OF NON-COVERED TREATMENT.** Except for breast surgery as outlined above, no benefits will be paid for care, services, or treatment required as a result of complications from a treatment not covered under this Plan.
- 7) **COSMETIC TREATMENT.** No benefits will be paid for Cosmetic Treatment, except for that which:
 - a) results from an Illness or Injury and is performed within six months of the date of such Illness or Injury; or
 - b) is indicated because of congenital birth defects.
- 8) **COURT MANDATED.** No benefits will be paid for services that are provided due to a court order except as required in the ERISA Requirements section under "MISCELLANEOUS PLAN PROVISIONS."
- 9) **CUSTODIAL CARE.** No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.
- 10) **DRUGS - POISON.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Illness or Injury to Covered Persons over the age of seven, which is due to:
 - a) the voluntary and intentional taking of drugs except those taken as prescribed by a Physician;
 - b) the voluntary and intentional taking of poison; or
 - c) the voluntary and intentional inhaling of gas.

However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

- 11) **DURABLE MEDICAL EQUIPMENT.** No benefits will be paid for the purchase of Durable Medical Equipment or supplies which remain with the Provider following the Covered Person's use thereof.
- 12) **EDUCATIONAL/RECREATIONAL/BIOFEEDBACK.** No benefits will be paid for any services or supplies deemed to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training, except educational services as listed in "MEDICAL BENEFITS" under 'Wellness Expense' due to the Patient Protection and Affordable Care Act (PPACA).
- 13) **EXPERIMENTAL/INVESTIGATIONAL.** Except as stated in "ELIGIBLE CHARGES," no benefits will be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational 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.
- 14) **EXERCISE PROGRAMS.** No benefits will be paid for exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, Occupational Therapy, or Physical Therapy covered by this Plan.
- 15) **FOOT CARE LIMITATION.** No benefits will be paid for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.
- 16) **GENETIC TESTING.** No benefits will be paid for genetic testing and counseling.
- 17) **GOVERNMENT AGENCIES.** No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.
- 18) **HAIR LOSS.** No benefits will be paid for the care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy and/or radiation.
- 19) **HAZARDOUS ACTIVITY.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Accident or Injury directly or indirectly attributable to participation in hazardous sporting activities including, but not limited to, motorcycle racing, off-road vehicle competitions, hang gliding, parasailing, drag racing, motor cross racing, road racing, and sporting stunts. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

- 20) **HEARING AIDS.** No benefits will be paid for examinations to determine the need for, or for the fitting or purchase of hearing aids.
- 21) **HOME MODIFICATIONS.** No benefits will be paid for home modifications, whether or not recommended by a Physician, such as but not limited to ramps, grab bars, or railings.
- 22) **HOSPITAL WEEKEND ADMISSIONS.** No benefits will be paid for the initial Friday, Saturday, and Sunday Room and Board charges incurred in connection with a Hospital confinement which begins on Friday, Saturday, or Sunday except for emergency Hospital admissions or scheduled surgery within the 24 hours immediately following Hospital admission.
- 23) **ILLEGAL ACTIVITY.** No benefits will be paid for any Illness or Injury which is incurred while taking part in an illegal activity, including but not limited to felonies, misdemeanors, or an attempt to commit a crime, regardless of whether the Covered Person is charged with, or convicted of, such activity.
- 24) **INFERTILITY.** No benefits will be paid for the treatment of infertility, artificial insemination, in vitro fertilization, GIFT, ZIFT, or other attempts to induce pregnancy, including drug therapy. Testing to determine a diagnosis of infertility is covered.
- 25) **JAW AND JAW JOINTS.** No benefits will be paid for Temporomandibular Joint Syndrome, osteotomy, orthognathic surgery, or maxillo facial or dental facial orthopedics.
- 26) **LEARNING/BEHAVIOR DISORDERS.** No benefits will be paid for special education, treatment, or training for learning or behavior disorders.
- 27) **LEGAL DUTY.** Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay.
- 28) No coverage will be provided for any services, supplies, or treatment (1) for which the Covered Person is not legally required to pay, (2) for which no charge would usually be made, (3) for which a charge if made would not usually be collected if no coverage existed, or (4) to the extent the charge for services, supplies, or treatment exceeds the charge that would have been made and collected if no coverage existed.
- 29) **MEDICALLY NECESSARY.** No benefits will be paid for charges which are not Medically Necessary.
- 30) **NICOTINE ADDICTION.** No benefits will be paid for the treatment of nicotine use or addiction.
- 31) **NO CHARGE.** No benefits will be paid for care and treatment for which there would not have been a charge if no coverage had been in force.

- 32) **NON-MEDICAL CHARGES.** No benefits will be paid for sales tax, interest, charges made for completion of claim forms or for providing supplemental information, or expenses incurred for failure to keep a scheduled appointment.
- 33) **NUTRITIONAL SUPPLEMENTS.** No benefits will be paid for vitamins, minerals, and food supplements whether or not prescribed by a Physician.
- 34) **OTHER.** Benefits will not be paid for charges not listed under “ELIGIBLE CHARGES.”
- 35) **OUTSIDE THE UNITED STATES.** No benefits will be paid for charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining medical services, drugs or supplies or to obtain those services, drugs, and supplies that are unavailable or illegal in the United States.
- 36) **PERSONAL COMFORT ITEMS.** No benefits will be paid for personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, whirlpool, water bed, exercise equipment, ultraviolet lighting, toilet seat, shower chair, electric heating units, breast pumps, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, slings, diapers, under pads, nonprescription drugs, first-aid supplies, and non-hospital adjustable beds.
- 37) **PHYSICIAN'S DIRECT CARE.** Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.
- 38) **PRESCRIPTIONS/MEDICATIONS.** No benefits will be paid for any prescriptions or medications unless purchased through the “PRESCRIPTION DRUG PROGRAM.”
- 39) **REASONABLE AND CUSTOMARY.** No benefits will be paid for charges which are more than the Reasonable Charge or Customary Charge.
- 40) **RELATIVE PERFORMING SERVICE.** No benefits will be paid for charges for the services of a Physician or any other Provider of services:
- a) who usually resides in the same household with the Covered Person; or
 - b) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.
- 41) **REPLACEMENT BRACES.** No benefits will be paid for replacement braces of 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.
- 42) **REVERSAL OF STERILIZATION.** No benefits will be paid for the reversal of sterilization.
- 43) **RIOT – CIVIL DISTURBANCE.** No benefits will be paid for any Illness or Injury which is incurred while taking part in a riot or civil disturbance.

- 44) **SELF-INFLICTED.** To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).
- 45) **SEXUAL DYSFUNCTION.** No benefits will be paid for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- 46) **SLEEP DISORDERS.** No benefits will be paid for the treatment of sleep disorders, unless deemed Medically Necessary.
- 47) **SUBSTANCE ABUSE/SUBSTANCE DEPENDENCE.** No benefits will be paid to treat physical, emotional, or physiological dependency on alcohol or drugs (whether legal or illegal) or any type of substance abuse or substance dependence.
- 48) **TELEPHONE CONSULTATIONS.** No benefits will be paid for telephone consultations or for any other charges by a Physician who is not physically present when consulting with the Covered Person.
- 49) **TREATMENT OF TEETH AND GUMS.** Except as described in “ELIGIBLE CHARGES,” no benefits will be paid for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.
- 50) **VISION CARE.** No benefits will be paid for:
- a) treatment of refractive errors including, but not limited to, routine eye examinations, eye glasses or contact lenses or the fitting of them, eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
 - b) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
- This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.
- 51) **WAR.** No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.
- 52) **WEIGHT CONTROL.** No benefits will be paid for the treatment of, or services or supplies related to, obesity, Morbid Obesity, weight control, or diet, including but not limited to surgery, treatment of complications or adverse reactions to any prior surgery, nutritional counseling, food products, and medications, except Morbid Obesity as stated in “ELIGIBLE CHARGES.”

- 53) **WORK RELATED ILLNESS OR INJURY.** No benefits will be provided for an Illness or Injury which arises out of or in the course of employment, regardless of whether workers' compensation or other similar coverage is available.

PRE-CERTIFICATION/CONTINUED STAY REVIEW. Except in certain cases concerning childbirth, a Covered Person must call Delphi at least 72 hours prior to Hospital admission for a medical condition, Mental or Nervous Disorder, Substance Abuse/Substance Dependence treatment, or Outpatient Surgical Procedures, and in case of an emergency hospitalization, must call within two working days following admission. The number for **Delphi** is **(888) 289-0700**.

The Covered Person must provide Delphi with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by Delphi.

The Delphi medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan's procedures for pre-admission or continued stay review, the pre-certification penalty described in "MEDICAL BENEFITS" will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

Pre-certification by Delphi does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.

MOTHERS AND NEWBORNS. Notwithstanding any other provision of this "MANAGED CARE" section, the Plan shall not:

- 1) restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) a normal vaginal delivery, to less than 48 hours, or (b) a cesarean section, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother; or
- 2) require any Covered Person or Provider to obtain authorization under the pre-certification features of this section in conjunction with any such stay that does not exceed the number of hours set forth in 1) above.

CASE MANAGEMENT PROGRAM. The case management program is a special program designed for Covered Persons who are suffering from a complex Illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

Case management is a voluntary service. There are no reductions of benefits or penalties if the Covered Person chooses not to participate.

ALTERNATIVE CARE. The Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it 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 to administer this Plan thereafter in strict accordance with its express terms.

COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:

- 1) group, blanket, or individual insurance;
- 2) Hospital or medical service pre-payment plans;
- 3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
- 4) government plans or programs;
- 5) coverage required or provided by law;
- 6) no fault auto insurance, including medical payments coverage ("MPC") and personal injury protection ("PIP");
- 7) third party liability insurance; and
- 8) any other source, including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

COORDINATION PROCEDURES. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below.

The primary plan pays its benefits first, without taking other plans into consideration. The secondary plan then pays benefits up to the extent of its liability, after taking into consideration the benefits provided by the other plan. Benefits under any other plan include benefits which the Covered Person could have received if such benefits had been claimed.

If the benefits paid by the secondary plan are less than the Plan would have paid as primary, the unused benefits will be set aside as COB savings. COB savings may be used to pay any benefits which are not covered by the normal payments of the primary and secondary plans, as long as the expense is allowable under one of the plans. COB savings is accrued on a Calendar Year basis and can only be used in the Calendar Year in which it has accrued.

No more than 100% of allowable expenses will be paid by the combination of this Plan, COB savings and any other plan(s). "Allowable expense" means any eligible charges which are Reasonable Charges, Customary Charges, Medically Necessary, and covered under at least one of the Plans. When this Plan is secondary (i.e., when this Plan pays after another Plan), "allowable expense" will include any Deductible or Coinsurance amounts not paid by the other plan. "Allowable expense" will not include any PPO, HMO, or other Provider discounts. An "allowable expense" will not include an expense incurred when coverage is not in effect under this Plan.

- 1) If a plan has no COB provision, it is automatically the primary plan;
- 2) If all the plans have COB provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a Dependent;
- 3) If a person is covered as a Dependent child under more than one plan:

- a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
- b) if the father and mother share the same birthday, the Plan covering the parent longer is the primary plan;
- c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
- d) if parents are separated or divorced, the following applies:
 - the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;
- 4) If a plan is no fault auto insurance (including MPC and PIP), required by law, or third party liability insurance, it is the primary plan; and
- 5) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS. This Plan will not consider any charges in excess of what an HMO or PPO Provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

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

RIGHT TO EXCHANGE DATA. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

PAYMENT AND OVERPAYMENT. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.

GOVERNMENT BENEFITS. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

EFFECT OF MEDICARE ON BENEFITS. A covered Employee who reaches age 65, and his spouse, may remain covered by the Plan unless the Employee or spouse makes an election to waive coverage under this Plan and chooses Medicare as the primary payer of benefits. In the event that an Employee or spouse waives coverage under this Plan and thereby elects Medicare as the primary source of benefits, no benefits will be payable under this Plan. If an Employee or spouse who is entitled to Medicare does not waive coverage under the Plan, Medicare will be the secondary payer of benefits.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease, or as of the date coverage under the Plan is exhausted, whichever occurs first.

SUBROGATION AND REIMBURSEMENT

WHEN THIS PROVISION APPLIES. You or your Dependent(s) (hereinafter "beneficiary") may incur medical or dental expenses because of Illness or Injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or dental expenses incurred. In these instances, the Plan has no duty or obligation to pay claims related to this Illness or Injury. However, if the Plan chooses to pay benefits, it has both a right of Subrogation and a right of Reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of Subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of Subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of Subrogation or Reimbursement shall be held in trust for the benefit of the Plan. Under this right of Reimbursement, the beneficiary will be required to reimburse the Plan out of any monies the beneficiary receives from the other person or on behalf of the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred. The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of Subrogation and Reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

The beneficiary may be required to execute a Subrogation Reimbursement Agreement and/or a Trust Agreement to receive benefits under the Plan. Failure to execute these documents upon request by the Plan Administrator may result in the non-payment of any related Claims. Further, if the beneficiary fails to return signed copies of these documents within the time period specified by the Plan Administrator, the Plan may refuse to pay Claims incurred with respect to the Illness or Injury from the date of your Injury or Illness through the date the Plan Administrator receives the signed documents. If the documents are received after the deadline established by the Plan Administrator, the Plan will pay eligible Claims incurred subsequent to its receipt of the signed documents.

Notwithstanding the foregoing, even if the Plan chooses not to have the beneficiary execute a Subrogation Reimbursement Agreement or the beneficiary fails to return a signed Subrogation Reimbursement Agreement, and the Plan pays any claims on behalf of the beneficiary and the beneficiary accepts payment of the claims, (1) the Plan will not be considered to have waived its right to pursue Subrogation and/or Reimbursement with respect to any claims it pays on behalf of the beneficiary, (2) the beneficiary will be deemed to have accepted the terms of the Plan, including the Subrogation and Reimbursement provisions described in this section, and (3) the beneficiary will be deemed to agree to maintain any payment received from another party in a constructive trust.

AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or dental benefits paid for the Illness or Injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of Subrogation and Reimbursement. In addition, the beneficiary must notify the Plan Administrator of any action, judgment, settlement or other recovery for which the Plan has rights of Subrogation and Reimbursement. Further, the beneficiary will do nothing to prejudice the right of the Plan to Subrogation or Reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

The beneficiary shall be entitled to recover payment for benefits under the Plan only once. In the event a beneficiary becomes entitled to recovery from the Plan Administrator for a work-related Illness or Injury, and the amount of such recovery includes amounts for medical benefits previously paid by the Plan, the Plan Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by the Plan.

DEFINED TERMS

- 1) **"Recovery"** means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
- 2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and
- 3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

RIGHTS OF RECOVERY. Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Covered Person or by a representative of a Covered Person, that complies with the Plan's procedure for making benefit Claims.

HOW TO MAKE A CLAIM:

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

- Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.
- Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.
- Step 3) If items 1 and/or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.
- Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.
- Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:
 - a) the employer's name, or group number;
 - b) the Employee's name;
 - c) the Employee's social security number or Employee identification number;
 - d) the patient's name;
 - e) the Physician's name;
 - f) the type of service rendered;
 - g) an itemization of the charges;
 - h) the condition for which the service was incurred;
 - i) the date of service; and
 - j) Accident/Injury detail, if applicable (can be provided by the Covered Person on a separate document).

Step 6) Forward Midlands Choice claims to:

Midlands Choice
PO Box 5809
Troy, MI 48007-5809

Forward PHCS claims to:

PHCS
PO Box 21823
Eagan, MN 55121
Payor ID: 28680

Forward dental claims to:

Group Resources
PO Box 100043
Duluth, GA 30096

Step 7) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

INTERNAL CLAIMS REVIEW PROCEDURES. For purposes of the claims procedures below, reference to an “adverse benefit determination” means a denial, reduction, termination of, or a failure to provide or make a payment, in whole or in part, for a benefit, including benefit determinations relating to a claimant’s eligibility, and determinations that particular services are experimental and/or investigational or not Medically Necessary or appropriate.

An adverse benefit determination also includes a “rescission of coverage.” A “rescission of coverage” is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to administrative delays or failure to timely pay contributions towards the cost of coverage.

TYPES OF CLAIMS AND TIME PERIOD FOR PROCESSING. There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. A period of time begins at the time the Claim is filed. “Days” means calendar days.

URGENT CARE CLAIM. A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care decision could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of the attending or consulting Physician, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Covered Person has failed to follow the Plan's procedure for filing a Claim:	
Notification to Covered Person of deficiency, orally or in writing	24 hours
Response by Covered Person, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	48 hours after receipt of additional information or expiration of Covered Person's time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method.

PRE-SERVICE CLAIM. A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see "MANAGED CARE" for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	15 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	15 days
Determination as to extending course of treatment	15 days
Review of adverse benefit determination	30 days

POST-SERVICE CLAIM. A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a claim that is a request for payment under the Plan for covered medical services already received by the Covered Person for which no prior approval was required. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	30 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Review of adverse benefit determination	60 days

NOTICE OF ADVERSE BENEFIT DETERMINATIONS. Except with Urgent Care Claims (in which event the notification may be given orally followed by written or electronic notification within three days of the oral notification), the Plan Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

- 1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- 2) the specific reason(s) for the adverse determination;
- 3) reference to the specific Plan provision(s) on which the determination was based;
- 4) a description of any additional material or information necessary for the Covered Person to perfect the Claim and an explanation of why such material or information is necessary;
- 5) a description of the available internal and external review procedures under the Plan (including information regarding how to initiate an appeal) and the time limits applicable to such procedures, including any expedited review procedures for urgent care Claims, as well as a statement regarding the Covered Person’s right to bring an action under Section 502(a) of ERISA following an adverse benefit determination on review;
- 6) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim; and
- 7) contact information for any applicable office of health insurance consumer assistance.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Covered Person upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not Medically Necessary or the Experimental/Investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

INTERNAL APPEAL OF ADVERSE BENEFIT DETERMINATION. When a Covered Person receives an adverse benefit determination, the Covered Person has 180 days following receipt of the notification in which to appeal the decision. Except as otherwise required by law, the right to appeal shall belong solely to the Covered Person seeking benefits, and may not be assigned, transferred or in any way conferred upon any other person or persons. Any such attempted assignment shall be void. Nothing in this Plan Document shall be construed to confer liability on the Plan, the Company or the Plan Administrator to any provider or assignee for medical care, treatment or other services provided to a Covered Person in the event of an attempted assignment of a Covered Person's right to appeal an adverse benefit determination.

A Covered Person may submit written comments, documents, records and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

NOTICE OF ADVERSE DETERMINATION ON INTERNAL APPEAL. The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:

- 1) information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning);
- 2) the specific reason(s) for the adverse determination;

- 3) reference to the specific Plan provision(s) upon which the determination was based;
- 4) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of all document, records, and other information relevant to the Covered Person Claim for benefits;
- 5) a statement describing any additional mandatory or voluntary appeal required or offered by the Plan (including the opportunity for External Review, if applicable), the Covered Person's right to obtain information about such procedures, and a statement of the Covered Person's right to bring suit under ERISA Section 502(a);
- 6) contact information for any applicable office of health insurance consumer assistance; and
- 7) any other information required by law.

In addition, if the determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

EXTERNAL REVIEW PROGRAM. The External Review Program offers an independent review process to review the denial of a requested service or procedures or the denial of payment for a service or procedures. The process is available at no charge following the Covered Person's exhaustion of the internal appeals process described above provided the claim meets one of the following requirements:

- The appeal relates to a rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- The Covered Person has received an unfavorable (or adverse) decision on appeal based on a medical judgment – *e.g.*, based on clinical reasons, the experimental treatment or similar exclusion or limit.

The External Review Program does *not* apply if the adverse benefit determination is based on an administrative determination, such as:

- eligibility;
- explicit benefit exclusions; or
- defined benefit limits.

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS EXCEPTION TO THE DEEMED EXHAUSTION RULE. A Covered Person will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Covered Person may proceed immediately to the External Review Program or make a claim in court.

However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Covered Person must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Covered Person as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Covered Person, and the violation is not reflective of a pattern or practice of non-compliance.

If a Covered Person believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Covered Person may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Covered Person with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

STANDARD EXTERNAL REVIEW. Under the External Review Program, after a Covered Person has exhausted his or her internal appeals, the Covered Person may request an independent review of an adverse benefit determination. An adverse benefit determination related to an individual's failure to meet the Plan's eligibility requirements is not eligible for external review.

All requests for an external review must be made within four months of the date the Covered Person receives the adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Covered Person, his or her treating Physician, or an authorized designated representative may request an external review by writing the Plan Administrator.

The Plan Administrator will review a request for external review within five business days of its receipt of the request to determine whether:

- the individual was covered under the Plan at the time the service was requested or provided;
- the adverse determination was based on medical judgment and does not relate to eligibility;
- the Covered Person has exhausted the Plan's internal appeals process, unless the Covered Person is not required to exhaust the internal appeals process due to the deemed exhaustion rule described above; and
- the Covered Person has provided all paperwork necessary to complete the external review.

The Plan Administrator will notify the individual in writing within one business day of the completion of its review, whether the adverse benefit determination is eligible for external review and if any additional information is required.

If the request is not eligible for external review, the notification will include the reasons why it is not eligible and contact information for the Employee Benefits Security Administration (866-444-EBSA). If the request was incomplete, the notification will state the information or materials needed to complete the request, and the Covered Person must supply the information by the later of:

- 1) the last day of the 4-month filing period described above; or
- 2) 48 hours after receipt of the Plan Administrator's notification.

If the adverse benefit determination is eligible for external review, the Plan Administrator will forward the request to an Independent Review Organization (IRO) with which the Plan has contracted. The IRO will be chosen based on a rotating list of at least three approved IROs. The IRO acts as a fiduciary of the Plan with respect to the external reviews that are delegated to the IRO.

The IRO will provide the Covered Person with a written notification that it has received and accepted the request for external review, and give the Covered Person the opportunity to submit additional information within 10 business days. The Plan Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If a claimant supplies additional information to the IRO, the IRO will forward that information to the Plan Administrator, at which point the Plan Administrator may reconsider its adverse benefit determination.

The IRO will review the claim without giving deference to the Plan Administrator's prior decisions, and will take into account any additional information the claimant has supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, medical records, physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IRO's clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both the Covered Person and the Plan. This notification will include:

- a general description of the reason for the request for external review, including sufficient information to identify the claim;
- the date the IRO received the request for external review and the date of its decision;
- reference to the evidence or documentation considered in reaching its decision;
- the reason(s) for its decision, including any evidence-based standards that were relied on;
- a statement that the determination is binding except to the extent other remedies are available under state or federal law;
- a statement that judicial review may be available; and
- current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and provide benefits for the service or procedure in accordance with the terms and conditions of the Plan. If the decision of the IRO confirms the Plan Administrator's adverse benefit determination, the Plan will not be obligated to provide benefits for the service or procedure.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years, and make them available for review by the Covered Person and the Plan Administrator upon request, except if the disclosure would violate State or Federal privacy laws.

EXPEDITED EXTERNAL REVIEW. An adverse benefit determination may be eligible for an expedited external review if:

- The Covered Person has received an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal (as described above) would seriously jeopardize the Covered Person's life or health, or his or her ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal, or
- The Covered Person has received an adverse benefit determination involving a medical condition for which the timeframe or completion of a standard external review would seriously jeopardize the Covered Person's life or health, or would jeopardize the Covered Person's ability to regain maximum function, or if the adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services, but has not been discharged from a facility.

If a Covered Person makes a request for an expedited external review, the Plan Administrator will immediately review the request and provide a written notice of whether the Covered Person's adverse benefit determination is eligible for external review. If the adverse benefit determination is eligible for external review, the Plan Administrator will forward the request to an IRO (electronically, by telephone or fax, or by other similar manner) as described above under the 'Standard External Review' procedures, along with all documents and information it considered in making its adverse benefit determination.

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both the Covered Person and the Plan with 48 hours thereafter.

For more information regarding external appeal rights and the independent review process, contact the Plan Administrator under "VENDOR LISTING."

QUESTIONS ON CLAIMS CALL:

GROUP RESOURCES AT: (800) 749-9963
MONDAY THROUGH FRIDAY, BETWEEN 8:00 AM AND 5:00 PM EST.
OR VISIT OUR WEBSITE AT: www.groupresources.com

PRE-ADMISSION CERTIFICATION CONTACT:

DELPHI AT: (888) 289-0700

THIS SERVICE IS AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK.

PROOF OF LOSS. A Claim must be made no later than one year from the date of service unless the Covered Person was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

PHYSICAL EXAMINATIONS. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

TIME BAR TO LEGAL ACTION. No legal action may be commenced or maintained against the Plan prior to the Covered Person's exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the plan more than 90 days after the Plan Administrator's decision on review. However, the 90-day period is tolled for any period during which an External Review is pursued, and such tolling will end as of the date of a notice of a final external review decision.

MISCELLANEOUS PLAN PROVISIONS

AMENDMENT OR TERMINATION. The continued maintenance of the Plan is completely voluntary on the part of the Company and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the Company intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

ERISA REQUIREMENTS. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the following requirements of ERISA Section 609:

- 1) Medical Child Support Orders. The Plan will comply with the requirements of any "qualified medical child support order" as defined in ERISA Section 609(a)(2)(a). The Plan Administrator will develop procedures to determine whether a medical child support order is qualified and for complying therewith. A Covered Person may obtain, without charge, a copy of these procedures upon request to the Plan Administrator;
- 2) Rights of States where Covered Persons are eligible for medical benefits. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(b) regarding:
 - a) assignments of rights;
 - b) enrollment and provision of benefits without regard to Medicaid eligibility; and
 - c) acquisition by states of rights of third parties;
- 3) Coverage of Dependent Children in Cases of Adoption. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(c) regarding the effective date of insurance for adopted Dependent children.

COMPLIANCE WITH FEDERAL LAWS. The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

- 1) Americans With Disabilities Act of 1990;
- 2) Family and Medical Leave Act of 1993;
- 3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
- 4) Health Insurance Portability and Accountability Act of 1996, as amended;
- 5) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
- 6) The Newborns' and Mothers' Health Protection Act of 1996;
- 7) The Mental Health Parity Act of 1996, as amended;
- 8) The Women's Health and Cancer Rights Act of 1998;
- 9) The U.S. Trade Promotion Authority Act of 2002;

- 10) The Working Families Tax Relief Act of 2004 (H.R.1308);
- 11) The Genetic Information Non-Discrimination Act of 2008;
- 12) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;
- 13) The American Recovery and Reinvestment Act of 2009, as amended (the “HITECH Act”);
- 14) The Children's Health Insurance Program Reauthorization Act of 2009;
- 15) The Patient Protection and Affordable Care Act of 2010;
- 16) The Trade Adjustment Assistance Extension Act of 2011; and
- 17) The requirements of the final modifications to the HIPAA Privacy, Security, Enforcement and Breach Notification Rules (75 Fed. Reg. 5566 (Jan. 25, 2013)).

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

PATIENT PROTECTION AND AFFORDABLE CARE ACT. This Plan believes it is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (the ‘Affordable Care Act’).

NON-DISCRIMINATION. Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or a Dependent of that individual with respect to health coverage on the basis of a health factor.

Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual’s enrollment in the Plan or coverage in connection with enrollment in the Plan.

GOVERNING LAW. The Plan shall be governed by ERISA and the regulations promulgated thereunder. Any assignee of a Covered Person under this Plan shall be treated as the Covered Person with respect to any claim or request for payment of expenses for medical services submitted to the Plan, the Plan Administrator, the Plan Sponsor, the Third Party Administrator, or any agent or Employee thereof. Any Claims or causes of action asserted by any Covered Person or assignee shall be subject to ERISA, and no state law Claims or causes of action shall be applicable with respect to any expenses related to the provision of health care services.

SEVERABILITY. If any provision, or any portion thereof, contained in this Plan is held to be unconstitutional, illegal, invalid, or unenforceable, the remainder of this Plan shall not be affected and shall remain in full force and effect.

ASSIGNABILITY. Amounts payable at any time may be used to make direct payments to health care Providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

No appeal rights granted to the Covered Person in this Plan may be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in the written description of the medical coverage shall be construed to make the Plan liable to any third-party to whom a Covered Person may be liable for medical care, treatment, or services.

NATIONAL CORRECT CODING INITIATIVE. Where not otherwise specified, this Plan follows National Correct Coding Initiative (“NCCI”) for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

PLAN INFORMATION

Name of the Plan: County of Dakota County
Employee Health Benefit Plan

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

County of Dakota County
1601 Broadway
Dakota City, NE 68731
(402) 987-2126

The Plan Administrator is responsible for the administration of the Plan and is the "Named Fiduciary" under the Employee Retirement Income Security Act of 1974, as amended.

Employer Identification Number (EIN): 47-6006449

Plan Number: 501

Type of Plan: Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the Company. While the Company may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan.

Name, address, and telephone number of the Administrative Service Agent:

Group Resources
3080 Premiere Parkway
Suite 100
Duluth, GA 30097-4904
(800) 749-9963

The designated agent for service of legal process is:

County of Dakota County
1601 Broadway
Dakota City, NE 68731

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

County of Dakota County
1601 Broadway
Dakota City, NE 68731

Claims Administration:

The plan is administered by the Plan Administrator, with Group Resources, an Administrative Service Agent, acting as Claims paying agent.

Plan Funding:

Company and Employee contributions cover the cost of the Plan. Company contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee's paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary.

The Plan fiscal year ends on:

February 28 or 29

STATEMENT OF ERISA RIGHTS

As a participant in the County of Dakota County Employee Health Benefit Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to the following:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court subsequent to exhausting the Plan's claim procedures.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Miscellaneous Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration at (866) 444-3272.