City of San Luis
EMPLOYEE BENEFIT TRUST – Mexico Coverage

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

EBSO GROUP NUMBER: SLS001

Effective: July 1, 2018

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, the Plan Sponsor establishes City of San Luis Employee Benefit Plan – Mexico Coverage (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of medical and prescription drug benefits. It is the intent of the Plan Sponsor to provide continuous eligibility and coverage from the previous plan to this Plan.

The Plan Sponsor hereby adopts this Plan Document as the written description of the Plan.

Disclaimer Of Claims Administrator

EBSO, Inc. has prepared this document for your review and consideration; however, we are not legal counsel, nor are we in the business of practicing law. As your Plan's fiduciary, you are fully responsible for all legal issues that concern the Plan. If you are not an expert in this area, we urge you to hire an attorney to help you review this Plan.

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

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Date Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Medical and surgical benefits to women who have undergone a mastectomy (a surgical procedure to remove the breast or breast tissue) were expanded under the federal Women's Health and Cancer Rights Act in 1998. The bill has a provision that requires health plans to provide coverage for certain mastectomy related procedures. As a Plan Member, you receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, breast prosthesis (artificial substitute), and physical complications of mastectomy including lymphedemas, surgery, and reconstruction of the other breast to produce a symmetrical appearance. Treatments are subject to the same Copays and Deductibles (where applicable) as other covered surgical procedures. For more information on Copays and Deductibles for surgical procedures, see the Schedule of Coverage.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

SECTION A

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

City of San Luis, the Employer, has established the City of San Luis Employee Benefit Trust – Mexico Coverage in order to provide comprehensive healthcare benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust – Mexico Coverage is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter "Plan"). The Plan is not an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). Any resemblance to an ERISA plan shall not be construed to mean it is an ERISA plan. The Plan is a self-insured medical plan intended to meet the requirements under Sections 105(b), 105(h) and 106 of the Internal Revenue Code of 1986 so the portion of the cost for coverage paid by the Employer is not taxable income to the Employee and any benefits received through the Plan are not taxable income to the Employee. This Plan is a group health plan for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and shall be administered in a manner consistent with HIPAA.

The Plan Sponsor has established the Plan for the benefit of eligible employees and their eligible dependents, on the terms and conditions described herein. The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

This Plan is a non-grandfathered plan under Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act (HCERA), collectively referred to as Health Care Reform.

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

The Schedule of Coverage is meant only as a summary of benefits. For more details about the benefits, check the Table of Contents and refer to the specific section in the booklet for complete terms and conditions.

This Plan covers only those expenses Incurred in connection with non-occupational injuries or disease.

The Employer has contracted with the Claims Administrator to perform certain consultative and management services related to the Plan. The Employer retains ultimate authority for the Plan.

Certain words in this Plan have precise meanings and will be capitalized and defined in the Definition section or where used in the text, so that you will pay special attention to them.

New Rescission of Coverage Rules. Under this Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

General Plan Information

Name of Plan:	City of San Luis Employee Benefit Trust – Mexico Coverage
Plan Sponsor:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Administrator: (Named Fiduciary)	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547
Plan Sponsor ID No. (EIN):	86-0376164
Fiscal Year:	January 1 through December 31
Plan Number:	501
EBSO Group Number:	SLS001
Type of Administration:	Self-funded Welfare Plan Prescription Drug Plan

Sources and Methods of Contributions to the Plan:	The Employer and the Employee share in the cost of the Plan. The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions. The Employer will provide a schedule of the applicable premiums during the initial enrollment, during open enrollment periods, on the Plan's annual renewal date and upon request. All contributions shall be held in the Trust. The Plan is "self-insured" which means that benefits are paid with assets from the Trust established by the Employer to pay benefits under the Plan.
Name of Trust	City of San Luis Employee Benefit Trust – Mexico Coverage
Trustees	For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust – Mexico Coverage
Claims Administrator:	EBSO, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 **Please Note:** EBSO, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Plan.
Agent for Legal Services:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547

This document is the Summary Benefit Description (SBD) that describes the basic features of the Plan and how the plan operates.

It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the Plan. The SBD should be read in its entirety because many of its provisions are interrelated.

SECTION B

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

There is no Deductible.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

Network:	$6,250	INDIVIDUAL	**Out-of-Network:**	$20,000 INDIVIDUAL
	$12,500	FAMILY		$40,000 FAMILY

The Network Annual Out-of-pocket Maximum and the Out-of-Network Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Coinsurance and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- **All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)**
- **Outpatient surgery**
- **Special Services, such as podiatry**
- **CT Scans, Pet Scans and MRIs**
- **Home Health Care**
- **Out-of-Network Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

SIARMED: $250 per service or
Out-of-Network (US providers): 40% of the total cost of the service.

THE NETWORK IS ADMINISTERED BY: SIARMED

The only Out-of-Network providers covered under this Plan are United States providers. All other Out-of-Network providers are NOT covered except in cases of an Emergency.

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are "Essential Health Benefits" as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

Benefit Description	**Mexico Coverage SIARMED - Plan pays**	**Out-of-Network – US Healthcare Providers only -Plan Pays**	**Additional Limitations and Explanations**
Ambulance Services -Air and Ground	Not available	50%	
Dental Hospitalization and Dental Services Office Visits	100% after a $25 Copay per visit	50%	
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	100% after a $5 Copay per visit	Hearing aids: 80% All other: 50%	Hearing aids are ***LIMITED*** to one per Coverage Year and only covered in US. In network covered services only include: • Nebulizer • Breast pump
Emergency Services and Urgent Care Services Emergency visit Urgent Care	 100% after a $250 Copay per visit 100% after a $20 Copay per visit	 100% after a $250 Copay per visit 50%	In an Emergency, as defined by the Plan, Out-of-Network Covered Expenses will be paid at the Siarmed level. Copay is waived if hospitalized and benefits revert to applicable inpatient hospital benefit.
Home Health Care	Not available	50%	***LIMITED*** to a maximum of 60 visits per Coverage Year.
Inpatient Hospital Services (Non-Emergency)/Outpatient Hospital Visits for more than 12 hours Outpatient surgery (less than 12 hours)	 100% after a $50 Copay per visit 100% after a $25 Copay per visit	 50% 50%	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only -Plan Pays	Additional Limitations and Explanations
Inpatient and Outpatient Physician Services			
Primary Care Physician/Specialist Office Visits (includes lab and X-ray)	100% after a $5 Copay per visit	50%	
Inpatient Visit	100%	50%	
Surgery (Physician's office)	100%	50%	
Surgery (other)	100%	50%	
Physician Services – Pathology, Anesthesiology , or Radiology	100%	50%	
Maternity			
Prenatal visits			
Initial visit	100% after a $5 Copay per visit	50%	
All other visits	100%	50%	
Hospital Services	100% after a $50 Copay per visit	50%	
Birthing Centers	Not available	50%	
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment			
Visits for more than 12 hours	100% after a $50 Copay per visit	50%	
Visits for less than 12 hours	100% after a $25 Copay per visit	50%	
Outpatient treatment	100% after a $5 Copay per visit	50%	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only -Plan Pays	Additional Limitations and Explanations
Outpatient Diagnostic Tests			
Complex - MRI, CT, PET Scans	100% after a $25 Copay per visit	50%	
Other X-rays and Laboratory tests	100% after a $5 Copay per visit	50%	
Outpatient Prescription Drugs			
Generic Drugs	100% after a $3 Copay per visit	50%	
Name Brand Drugs	100% after a $6 Copay per visit	50%	
Preventive Care Services			Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.
Pediatric and Adult Preventive Care	100%	50%	
Immunizations, inoculations, vaccinations	100%	50%	
Sterilization – limited to Employee and covered Spouse only	100%	50%	
Rehabilitation and Habilitation Services	100% after a $5 Copay per visit	50%	Siarmed covered services in Mexico include physical and speech therapy only. Out-of-Network: Speech, occupational, and physical therapies covered at US providers only.
Skilled Nursing Facility	Not available	50%	***LIMITED*** to a maximum of 90 days per Coverage Year.
All other Covered Expenses	100%	50%	

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SECTION C

DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALLOWED CHARGE means the maximum dollar amount eligible for payment for a procedure or service as determined by the Plan. This includes billed charges, contracted amounts or Usual, Customary and Responsible Fees, depending on the healthcare provider's relationship with the Plan and/or the healthcare services provided.

AMBULATORY SURGICAL CENTER means a facility with an organized staff of Physicians which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

2. Provides treatment by and under the supervision of Physicians and nursing services when the patient is in the facility;

3. Does not provide Inpatient accommodations;

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician.

ANNUAL OUT-OF-POCKET MAXIMUM means the total Coinsurance and Copay amounts for certain Covered Services that are a Plan Member's responsibility during a Coverage Year. The following amounts are *not* considered or taken into account: charges that are not Covered Services under the Plan (e.g., charges which exceed Usual, Customary and Reasonable Fee and costs paid by the Plan Member as a result of a failure to comply with Prior Authorization requirements), and charges in excess of Plan maximums. When the Annual Out-of-Pocket Maximum is met, the Plan will pay 100% of the Allowed Charge for certain Covered Services incurred during the remainder of the Coverage Year. The Annual Out-of-Pocket Maximum renews on the Plan anniversary of each consecutive Coverage Year.

BIRTHING CENTER means a facility operating as part of a Hospital, or as a free-standing facility solely engaged in providing an alternative to conventional obstetrics which:

1. Is licensed as such and is operating within the scope of its license; and

2. Is directed by a Physician specializing in obstetrics or gynecology; and

3. Has a Physician or certified nurse mid-wife, present at all births and during the immediate post-partum; and

4. Is equipped and has a trained staff, or has a written agreement with the Hospital to handle emergencies including the transfer of a patient or child; and

5. Maintains medical records on each patient and provides an ongoing quality assurance program.

CALENDAR YEAR means the period from January 1 through the following December 31.

CONFINEMENT means a continuous stay in the Hospital(s) or extended care facility(ies) or combination thereof, due to a Sickness or Injury diagnosed by a Physician, which lasts at least one day and one night.

COPAY means an amount payable by the Plan Member before benefits are payable by the Plan. In some instances, the Plan Member will be responsible at the time and place of service to pay any Copay directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services after any applicable Copays have been paid and until the Annual Out-of-Pocket Maximum has been reached. Covered Services subject to Coinsurance and the amounts are listed in the Schedule of Coverage. Coinsurance is a percentage of the Allowed Charge. In some instances, the Plan Member will be responsible at the time and place of service to pay any Coinsurance directly to the healthcare provider. In other instances, the Plan Member will be billed by the healthcare provider. These arrangements are between the Plan Member and the healthcare provider.

COSMETIC PROCEDURE means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily

function. Breast reconstruction or a breast prosthesis following a mastectomy is ***NOT*** considered a Cosmetic Procedure.

COVERAGE YEAR means when services are covered under this Plan. This means that benefit maximums, Deductibles and Coinsurance limits start and stop during this time. The Plan's Coverage Year is January 1 – December 31.

COVERED SERVICE means healthcare services described in the Plan for which benefits will be provided, unless limited or excluded in the Plan. A Covered Service is Incurred on the date the healthcare service is received.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible, Copay and Coinsurance provisions where applicable and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

CREDITABLE COVERAGE means the period of time that an individual has been covered by any of the following medical programs:

1. This Plan;
2. Another group health plan;
3. Non-group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO;
4. Medicare (Part A or Part B);
5. Medicaid;
6. Title 10 U.S.C. Chapter 55;
7. American Indian Health Care Programs;
8. A state health benefits risk pool;
9. The Federal Employees Health Plan;
10. A "public health plan" including any plans established or maintained by a state, the U.S. government, a foreign country, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;

11. The Peace Corp Health Program;

12. A State Children's Health Insurance Program (S-CHIP).

CUSTODIAL CARE means the type of care that is designed chiefly to help a person meet activities of daily living. It does not entail or need the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses. Custodial Care includes services which make up personal care such as help in walking and getting in and out of bed; help in bathing, dressing, feeding, and using the toilet; preparation of special diets; and supervision of medication which usually can be self-administered. Care may still be custodial even though it involves the use of technical medical skills if those skills can be easily taught to a lay person.

DAY HOSPITALIZATION means the continuous treatment of a Mental/Nervous Disorders and/or Substance Abuse at a Hospital, intermediate care facility or other covered facility for not less than five hours and not more than eighteen hours in any 24-hour period. It does not include an Inpatient stay in the Hospital.

DENTIST means a duly licensed Dentist or Physician who is acting within the scope of his/her license.

DEPENDENT includes only an Employee's:

1. Spouse (Spouse means an individual as recognized as a spouse for purposes of federal tax laws, including the Code. A Spouse who is legally separated or divorced from the Employee is specifically excluded from the definition of Spouse); and

2. Unmarried or married children who are less than 26 years of age;

3. Unmarried children age 26 or older who are incapable of self-sustaining employment because of a developmental disability or physical disability and are chiefly dependent upon the Employee for support and maintenance. Proof of such incapacity must be furnished within 31 days of the children reaching the limiting age and annually thereafter.

   "Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, or other neurological disorder.

   "Physical disability" means a physical impairment that substantially limits one or more major life activities such as hearing; breathing; mobility (ability to move); learning; or receptive (understanding) and expressive

language. Physical disabilities include but are not limited to: blindness/visual impairment; cancer; diabetes; head injury; heart disease; and mobility impairments. An individual with a minor, non-chronic condition of short duration, such as a sprain, broken limb, or the flu, is not considered disabled.

4. Child for whom coverage is required by a Qualified Medical Child Support Order or by an administrative process established under state law.

The term children includes the following:

1. A biological child;

2. An adopted child, including a child placed for adoption. Placement for adoption occurs when an Employee, in anticipation of adopting a child, assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases;

3. A stepchild;

4. a child for whom the Employee and/or the Employee's Spouse has been named legal guardian, or

5. A child for whom the Employee is legally financially responsible.

6. A foster child.

At any time, the Plan may require proof that a spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan.

Individuals specifically excluded from the definition of a Dependent are:

1. any person on active military duty;
2. the grandchild of an Employee and/ or the Employee's Spouse;
3. any person covered under this Plan as an Employee; and
4. any person covered as a Dependent by another Employee.

DIAGNOSTIC means a test or procedure performed because the Plan Member has specific symptoms or which is required to detect or monitor a certain condition or disease. Such test or procedure must be ordered by a Physician or Health Care Professional, and it must be related to the Plan Member's symptoms.

DURABLE MEDICAL EQUIPMENT means equipment which is prescribed by a Physician and is primarily and customarily used to serve a medical purpose, able to

withstand repeated use, and not generally useful to a person in the absence of an Injury or Sickness.

EBSO means EBSO, Inc.

EFFECTIVE DATE means the date on which a person's coverage under this Plan begins.

EMERGENCY/EMERGENCY CONDITION means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

2. Serious impairment to such person's bodily functions;

3. Serious dysfunction of any bodily organ or part of such person; or

4. Serious disfigurement of such person.

EMERGENCY SERVICES means with respect to an Emergency Condition:

1. a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

2. such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as required to stabilize the patient.

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

EMPLOYER means City of San Luis.

ESSENTIAL HEALTH BENEFITS means:

1. Ambulatory patient services;

2. Emergency services;

3. Hospitalization;

4. Maternity and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;

8. Laboratory services;

9. Preventive and wellness services and chronic disease management; and

10. Pediatric services, including oral and vision care.

EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

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

3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

HEALTH CARE PROFESSIONAL means a licensed health care practitioner, other than a Physician (as defined by this Plan), who is legally licensed or certified and, within the scope of that license or certificate, is permitted to perform the services for which benefits are provided under this Plan. The term "Health Care Professional" includes, but is not limited to: a registered dietician, nurse midwife, audiologist, Physician's assistant, psychologist, nurse anesthetist, certified nurse practitioner, physical therapist, occupational therapist, speech therapist, speech pathologist, DME provider, License Practical Nurse (L.P.N.), Advanced Practice Registered Nurse, Radiation Therapist, Registered Nurse (R.N.), respiratory therapist, and an operating room technician (only when an assistant surgeon is not present). The Health Care Professional may be an independent Health Care Professional, however, his/her services must be recommended and approved by the Plan Member's attending Physician. The Health Care Professional may not be a member of the Plan Member's Immediate Family or a person who normally resides with the Plan Member.

HOME HEALTH CARE means care and treatment of a Plan Member provided by or coordinated through:

1. A Home Health Care Agency; or

2. A certified rehabilitation agency.

The care and treatment must be included in a Plan of Home Health Care approved in writing by the attending Physician. The Plan of Home Health Care must be revised every two months unless the attending Physician indicates in writing that a longer review period is sufficient. If the Plan Member was Hospital confined immediately prior to requiring home care, the Plan of Home Health Care must be approved by the Physician who was the primary provider of services during the confinement.

HOME HEALTH CARE AGENCY means a home health agency or a visiting nurses' association which meets all of the following requirements:

1. Is licensed by the state;

2. Qualifies as a Home Health Care Agency under Medicare;

3. Meets the standards of the applicable area-wide health care planning agency;

4. Provides skilled nursing services and other services on a visiting basis in the patient's home;

5. Is responsible for administering a Plan of Home Health Care; and

6. Supervises the delivery of a Plan of Home Health Care as prescribed and approved in writing by the patient's attending Physician.

HOME HEALTH CARE SERVICES means nursing services; dietary advice; social service guidance; physical, occupational, speech or respiratory therapy; laboratory services; drugs; dressings and medical supplies; and related services under the direction of a licensed Physician or surgeon provided in the place of and as an extension of care in a Hospital.

HOSPICE/HOSPICE CARE means an organization that provides medical, social and psychological services as palliative treatment for Plan Members with a terminal illness and life expectancy of less than six months.

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

1. It is accredited as a general Hospital by the Joint Commission on Accreditation of Hospitals;

2. It is open at all times;

3. It is operated chiefly for the treatment of sick or injured persons as Inpatients;

4. It has a staff of one or more Physicians available at all time;

5. It provides 24-hour nursing service by graduate registered nurses; and

6. It includes areas designed for diagnosis and major surgical procedures. Or, if it is chiefly a place for the treatment of mentally handicapped persons, it has an agreement, by contract or otherwise, with an accredited Hospital to perform Surgery which may be required.

The term "Hospital" does ***NOT*** include: a convalescent, nursing, rest, or Skilled Nursing Facility.

HOSPITAL MISCELLANEOUS EXPENSES means the actual charges made by a Hospital, other than room and board, on its own behalf for services and supplies rendered to the Plan Member, on an Inpatient or Outpatient basis, which are Medically Necessary for the treatment of such Plan Member. This includes Hospital admission kits, but all other personal or convenience items are excluded.

IMMEDIATE FAMILY means the Plan Member's spouse, children, brothers, sisters, grandparents, or the parents of the Plan Member or his/her spouse.

INCURRED means the day and time of day Covered Expenses are provided. It does not include a date on which a Plan Member contracts for future delivery of supplies or services.

INJURY means a condition caused by accidental means which results in damage to the Plan Member's body from an external force and independently of all other causes and which is ***NOT*** related to occupation or employment. Chewing accidents are ***NOT*** considered Injuries. Muscle strain due to athletic activity or other exertion is considered a Sickness under the Plan.

INPATIENT means that a Plan Member is confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or other covered facility.

INSTITUTIONAL HEALTHCARE PROVIDER means healthcare providers including an Ambulatory Surgical Facility or Urgent Care Facility.

INTENSIVE CARE UNIT means a specialized section, ward or wing, within a Hospital which is operated exclusively for critically ill patients (other than Hospice patients) and provides special supplies, equipment and constant observation and care by registered professional nurses or other highly trained Hospital personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or service.

MAINTENANCE CARE means continued care to maintain the optimum state of health after the Plan Member has reached a maximum level of recovery.

MASTER PLAN DOCUMENT means the Plan Document detailing the provisions of the Plan.

MEDICAID means the medical benefits provided by Title XIX of the Social Security Act, as amended.

MEDICALLY NECESSARY or **MEDICAL NECESSITY** means that a service, medicine or supply is necessary and appropriate for the diagnosis or active treatment of an Injury or Sickness based on generally accepted current medical practice.

To be Medically Necessary, Covered Expenses must:

1. Be rendered in connection with an Injury or Sickness;

2. Be consistent with the diagnosis and treatment of the Plan Member's condition; and

3. Be in accordance with the standards of good medical practice.

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

A service, medicine or supply will ***NOT*** be considered Medically Necessary if:

1. It is provided only as a convenience to the Plan Member or provider;

2. It is not appropriate treatment for the Plan Member's diagnosis or symptoms;

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

4. It is part of a plan of treatment that is considered to be Experimental/Investigational/Investigative in the diagnosis or treatment of an Injury or Sickness;

5. It involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required.

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

MEDICARE means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

MENTAL/NERVOUS DISORDER(S) means a psychiatric or emotional disorder recognized as such by the American Psychiatric Association. "Mental/Nervous Disorders" include but is not limited to: psychotic, bi-polar, psychoneurotic disorders.

NURSE MIDWIFE means a person certified as a Nurse-Midwife to assist with childbirth under the direction and supervision of a licensed Physician.

OUT-OF-NETWORK means Health Care Professionals that are not in the Siarmed Network. There is no Out-of-Network coverage under this Plan, except for Health Care Professionals located in the United States, or Medically Necessary Emergency Services provided by non-Siarmed healthcare providers in Mexico.

OUTPATIENT means treatment rendered to a Plan Member at: a clinic; an Ambulatory Surgical Center; a Physician's office; or at a Hospital or other covered facility, other than as an overnight bed patient.

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible amount or Copay amount, if applicable. The Payment Percentage is shown in the Schedule of Coverage.

PHYSICIAN means a legally licensed doctor of medicine and Surgery, doctor of optometry, psychiatrist, osteopathy, podiatric medicine, surgical chiropody, or doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

PLAN means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

PLAN YEAR means the twelve month period beginning from the effective date of this Plan. This Plan’s Plan Year is July 1st through June 30th. The Plan Year may not be the same as the Coverage Year.

PLAN OF HOME HEALTH CARE for purposes of the Home Health Care benefit means a program for continued care and treatment of the Plan Member established and approved in writing by the Plan Member's attending Physician within 7 days following termination of a Hospital confinement as a resident Inpatient, and which is for the same or related condition for which the Plan Member was hospitalized. The attending

Physician must certify, and recertify every 90 days, that the proper treatment of the Injury or Sickness would require continued confinement as a resident Inpatient in a Hospital or in a Skilled Nursing Facility in the absence of the services and supplies provided as part of the Plan of Home Health Care.

PLAN MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

PRESCRIPTION DRUG means medications and drugs that bear the legend "Federal law prohibits dispensing without a prescription." This term also includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a Physician or other authorized Health Care Professional and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets and testing strips) are generally covered as Prescription Drugs as well. Prescription Drugs include:

1. **Brand Name Drug** - a patent-protected Prescription Drug.

2. **Generic Drug** - Typically, a Prescription Drug on which patent has expired and manufactured by multiple pharmaceutical companies. FDA A-rated Generic Drugs (which are the only type of Generic Drugs covered under the Plan) contain the same active ingredient as the Brand Name Drug, are manufactured under the same FDA standards and are considered equivalent in all respects to the Brand Name Drug. Designation of Generic status is made by MediSpan, an independent, third party provider of prescription drug information based on the number of manufacturers of a given product and the price differential between the original product and subsequent manufacturers.

3. **Specialty Drug** – a Prescription Drug used to treat a specific, sometimes rare, medical condition. Specialty Drugs are typically expensive, often including bioengineered products, and require special handling, administration, monitoring, and patient education.

PRIMARY CARE PHYSICIAN means a Family Practitioner, General Practitioner, Pediatrician, OB/GYN, Internal Medicine Specialist, or Chiropractor.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, including the Plan, and relates to:

1. A person's past, present or future physical or mental health;

2. Provision of health care to that person; or

3. Past, present or future payment for that person's health care.

To be considered Protected Health Information the information must be "individually identifiable health information" which means that in addition to the above requirements, the health information must identify the individual or a reasonable basis must exist to believe that an individual can be identified using the information. Protected Health Information covers information in any form (electronic, oral or written).

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) means a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Plan Member or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address of the Plan Member and the name and mailing address of each such Alternate Recipient covered by the order;

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

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

4. The name of this Plan.

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

1. Contains the information set forth below;

    a. Name of an issuing state agency;

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

    c. Identity of an underlying child support order;

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

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

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

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Plan Members, except to the extent necessary to meet the requirements of a state law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

REHABILITATION FACILITY means a facility accredited by the Joint Commission on the Accreditation of Health Care Organizations or the Commission on the Accreditation of Rehabilitative Facilities as a Rehabilitation Facility for the primary purpose of physical rehabilitation. This facility may also be a ward, floor or other area contained within a Hospital whose primary purpose is physical rehabilitation.

RESCISSION or **RESCIND** means a cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect. Such action is prohibited under Health Care Reform unless attributable to (a) a failure to timely pay the cost of coverage, or (b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

RESPITE CARE means care provided to a Plan Member receiving Covered Services for Hospice care, for the purpose of giving the Plan Member's uncompensated primary caregivers relief when necessary in order to maintain the Plan Member at home.

ROUTINE means any physical examination, including all related x-ray and laboratory tests, or any other medical procedure performed when the Plan Member is asymptomatic (i.e., which are ***NOT*** Medically Necessary for the diagnosis of a specific Injury or Sickness), including those performed on a Physician's recommendation due to the patient's family history.

SCHEDULE OF COVERAGE means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

SECOND SURGICAL OPINION means a second opinion to evaluate the need for elective Surgery previously recommended by the patient's Physician provided that:

1. The charges that would be made for the recommended Surgery, if performed, must qualify as Covered Expenses;

2. The Physician furnishing the second opinion must not be financially associated with the Physician rendering the first opinion, and must be Board Certified in the appropriate medical specialty except: a Board Certified specialist is not required if the Physician has been recommended to the patient by a local medical society; and

3. The second opinion must be set forth in writing by the second Physician after the examination of the patient.

SIARMED NETWORK means the Siarmed network of Health Care Professional. For the Prescription Drug benefit, Siarmed Network shall mean the pharmacy network (as indicated on the ID Card). For medical and behavioral health services, Siarmed Network shall mean the Siarmed network in Mexico.

SICKNESS means a disorder of the body, a disease, condition, Mental/Nervous Disorder(s), Substance Abuse, pregnancy, or complication of pregnancy. All Sicknesses which are due to the same cause or to a related cause or causes will be deemed to be a Sickness.

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

1. It is licensed according to state or local laws;

2. Its chief purpose is to provide skilled nursing treatment to a Plan Member who is recovering from an Injury or Sickness;

3. It includes areas for medical treatment;

4. It provides 24-hour nursing service under the full-time supervision of a Physician or a graduate registered nurse (R.N.);

5. It maintains daily health records for each patient;

6. It has an agreement which provides for the services of a Physician;

7. It has a suitable method for providing drugs and medicines to patients;

8. It has an arrangement with one or more Hospitals for the transfer of patients;

9. It has an effective utilization review plan;

10. Its functions are developed with the advice and review of a skilled group which includes at least one Physician;

11. It is ***NOT*** solely a place for:

    a. Rest, rehabilitation or Custodial Care;

    b. The aged;

    c. Treatment of Substance Abuse; or

    d. Those who are mentally handicapped or who have Mental/Nervous Disorders.

SPECIALIST means a Physician other than a Primary Care Physician.

SUBSTANCE ABUSE means the overuse or addiction to alcohol and/or other drugs to the extent that is physically or mentally detrimental to the Plan Member, ***EXCLUDING*** nicotine and/or caffeine overuse or addiction.

SUMMARY HEALTH INFORMATION may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

SURGERY means:

1. The performance of generally accepted operative and cutting procedures. This includes related surgical supplies, specialized instrumentations, endoscopic examinations and other invasive procedures.

2. The correction of fractures and dislocations.

3. Injections of medication into joints and bursae for nerve blocks or as an alternative to Surgery, and injections of sclerosing agents and dyes used for radio-opacity.

4. Usual and related pre-operative and post-operative care.

URGENT CARE CENTER means a facility engaged primarily in providing minor emergency and episodic medical care. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance when the facility is open. The facility must include x-ray and laboratory equipment and life support equipment. For the purpose of this Plan, a facility meeting these requirements will be considered an Urgent Care Center, by whatever name it may be called.

USUAL, CUSTOMARY AND REASONABLE FEE means a charge for a given service by a provider to the majority of his clients, but such charge must be one which is within the range of fees charged by the majority of providers of similar training and experience, for that service within a specific, limited geographic or socioeconomic area as determined by the Plan. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of a level of expenses.

The Usual, Customary and Reasonable Fee for surgical procedures mean Covered Expenses for the services of a Physician for performing an operation.

SECTION D

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

EMPLOYEE ELIGIBILITY DATE

For new Employees, coverage becomes available on the first of the month following the date of hire.

Employee absences due to health related factors will be credited toward the eligibility waiting periods. **NOTE**: The Plan will give credit for any waiting periods satisfied in whole or in part under the Employers' previous plan of benefits.

The above requirement regarding length of employment shall be waived in any instance where a Plan Member is merely changing from Dependent status to Employee status, or vice versa. In these instances, coverage shall continue without interruption.

If an Employee loses coverage in this Plan due to Injury, Sickness, layoff, or Employer approved leave of absence and returns to work for the Employer within 3 months of the loss of coverage, he/she will be eligible for coverage on the date of return to work and will ***NOT*** have to satisfy a new waiting period.

NOTE: If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage within 30 days from the date he/she first satisfied the eligibility requirements.

DEPENDENT ELIGIBILITY DATE

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;

2. The date the Employee acquires an eligible Dependent; or

3. The date the Employee is required, by a Qualified Medical Child Support Order or by an administrative process established under state law, to provide Dependent coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE

A Dependent whose coverage is required under a medical support order will be eligible to participate in the Plan as of the date specified in the order, provided the medical support order satisfies the requirements of Arizona law. The Employer will review a medical support order and determine whether it is qualified under Arizona law. Upon request to the Employer, Members may obtain a copy of the procedures governing medical support order determinations, which is available at no charge.

All other Dependent coverage will become effective on the first of the month following one month from the Employee's date of hire. If Dependent status is acquired after the Employee's initial eligibility, the effective date of coverage shall be one month following the month in which the new Dependent becomes eligible for coverage under the Plan, provided the Employee completes a change form and submits it to the Employer within thirty (30) days after the attainment of Dependent status.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

NOTE: If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period or the Open Enrollment Period, as explained elsewhere in the Plan Document.

CHANGE IN STATUS

If an Employee is covered for single coverage and wants to change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment form within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Notwithstanding the foregoing, with respect to an Employee who acquires a new Dependent via birth, adoption, or placement for adoption, coverage for the new Dependent shall begin immediately upon birth, adoption, or placement for adoption and shall not be conditioned upon the enrollment of the new Dependent. However, if an additional premium is charged for the new Dependent and if the new Dependent fails to enroll with-in the thirty-one (31) day time period referenced above, the coverage shall cease upon expiration of such time period. Even if no additional premium is charged, the Employee should notify the Employer of the birth, adoption, or placement for adoption.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision or the Open Enrollment Period.

SPECIAL ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 31 days after other coverage ends. Coverage becomes effective on the first of the month following the date on which the request for enrollment was received by the Employer.

This special enrollment period ***ONLY*** applies to individuals whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or

2. Was not under COBRA and they lost that prior Creditable Coverage due to:

    a. events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, termination or reduction in hours of employment or a child aging out under other parent's coverage);

    b. the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees);

    c. the cessation of the employer contributions for that prior Creditable Coverage (actual termination of other coverage is not required);

    d. moving out of an HMO's service area; or

    e. reaching a lifetime limit for all benefits.

However, loss of eligibility does **NOT** include a loss due to failure of the individual to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

An Employee must make a request for Special Enrollment within 31 days of the loss of the previous Creditable Coverage and must supply the Plan with proof of loss of coverage under the other group health plan.

Additional Special Enrollment rights exist for Employees and their Dependents (who are eligible but not enrolled for coverage) upon either (1) termination of Medicaid or the State Children's Health Insurance Program (SCHIP) coverage resulting from loss of eligibility; or (2) becoming eligible for premium assistance in this Plan under a Medicaid or SCHIP program. In order to be entitled to this Special Enrollment right, the Employee must request coverage within 60 days of termination or the date the parent or child is determined to be eligible for assistance.

In addition, if an Employee, who declined coverage in this Plan for himself/herself or for his/her Dependents, acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her spouse and/or the new child, provided that the Employee requests coverage within 31 days after the marriage, birth, adoption or placement for adoption.

EXAMPLES:

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision. Coverage becomes effective on the date of marriage.

2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision. Coverage becomes effective on the child's date of birth, adoption or placement for adoption.

NOTE: During a Special Enrollment, the Employee may add a new Dependent under the Employee's current plan option or the Employee may switch to another option, **if applicable** (e.g., an Employee who is covered under this Plan may switch to an HMO plan offered by the Employer or change from one option under this Plan to another option under this Plan).

OPEN ENROLLMENT PERIOD

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) at the time such individuals are eligible for coverage, the Employee will be able to enroll himself/herself and/or his/her eligible Dependents during any Open Enrollment Period. Each year, during the month of **May**, the Employer will offer an Open Enrollment Period to eligible individuals (Employees and Dependents) who are not already covered under this Plan. Any individual enrolling for coverage under this Plan during an Open Enrollment Period (other than a new Employee who has not yet satisfied his/her eligibility-waiting period) will have coverage effective on the first of July.

NOTE: An Employee's eligible Dependent(s) may ***NOT*** be covered under this Plan unless the Employee is also covered. (This limitation does not apply to COBRA coverage.)

CHOOSING PLAN OPTIONS

Every year, during the month of May, the Employer will offer an annual enrollment period, during which an Employee who is presently enrolled under one Plan Option may elect to become enrolled in an alternate Plan Option. The effective date of the change in Plan Option will be July 1.

Employees who are presently enrolled under one Plan Option may also elect to become enrolled in an alternate Plan Option if they experience a family status change. A family status change will occur if the Employee gains or loses an eligible Dependent due to divorce, death, loss of eligibility, birth, marriage, adoption or a child reaching the maximum age limit.

Dependents covered by that Employee must be covered under the same Plan Option.

TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate at midnight on the earliest of the following:

1. The date the Plan is terminated for all Plan Members;

2. The date a required contribution, if any, is due but the Plan Member fails to make the contribution;

3. With regard to a specific benefit, on the date the benefit is terminated or deleted from the Plan;

4. The date the Plan Member requests termination of any or all coverage under the Plan, subject to IRS Cafeteria rules. The request for termination must be in writing and all forms required by the Plan Administrator must be completed;

5. For Employees: If an Employee does not work the required number of hours to be considered an eligible Employee for any reason other than those specifically listed above, (i.e.; voluntary or involuntary termination of employment; or reduction in hours), coverage will terminate at the end of the month in which the Employee ceases full-time active work;

6. For Dependents:

   a. Coverage will terminate on the same day as coverage terminates for the Employee under whom they are covered;

   b. Coverage will terminate at the end of the month in which the individual no longer meets the Plan's Definition of an eligible Dependent;

   c. For Dependents whose coverage became effective upon their birth, adoption, or placement for adoption under Change in Status, coverage will terminate on the date thirty-one (31) days from the effective date of coverage if an additional premium is charged for the new Dependent and the new Dependent fails to enroll with-in thirty-one (31) days following the birth, adoption, or placement for adoption.

   d. Coverage will terminate on the date as specified in the Qualified Medical Child Support Order or by an administrative process established under state law if eligibility for Dependent coverage is solely based on this order.

NOTE: Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or

2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

Rescission. Coverage under this Plan may be Rescinded under certain circumstances. A determination by the Plan that a Rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Plan Member whose coverage is being Rescinded will be provided a 30 day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice

period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims.

This Plan shall at all times be in compliance with the applicable state family medical leave act and/or the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with such acts. The FMLA will run concurrently with any extension of coverage specified above.

SECTION E

CONTINUATION OF COVERAGE UPON INDIVIDUAL TERMINATION (COBRA)

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The following paragraphs generally explain COBRA coverage, when it may become available and what a Qualified Beneficiary needs to do to protect his or her right to receive it.

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a Qualified Beneficiary.

WHAT IS COBRA CONTINUATION COVERAGE? COBRA coverage is a temporary extension of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below in the section entitled "What is a Qualifying Event".

The Plan has the following components, Medical and Prescription Drugs, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in the plan document and summary plan description "SPD") applies only to the group health plan benefits offered under the Plan (the Medical and Prescription Drugs) and not to any other benefits offered by the Employer (such as life insurance, disability income, or accidental death or dismemberment benefits).

COBRA coverage is the same coverage that the Plan gives to other Plan Members under the Plan who are not receiving COBRA coverage. Each Qualified Beneficiary who elects COBRA will have the same rights under the Plan as other Plan Members covered under the component or components of the Plan elected by the Qualified Beneficiary, including Open Enrollment and Special Enrollment rights.

If an Employer offers more than one level of benefits and also offers an Open Enrollment Period (during which time, Plan Members are allowed to change to a different level of benefits or to add additional coverage, such as dental or vision), Qualified Beneficiaries must also be allowed to make these selections during an Open Enrollment Period.

In considering whether or not to take COBRA, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. You will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not obtain continuation coverage for the maximum time available to you. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the Qualifying Event. You will also have the same special enrollment right at the end of continuation coverage if you obtained continuation coverage for the maximum time available to you.

WHO IS A QUALIFIED BENEFICIARY? In general, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent child of a covered Employee.

2. A child born to, adopted by, or placed for adoption with a covered Employee during a period of COBRA coverage is considered to be a Qualified Beneficiary provided that, if the covered Employee is a Qualified Beneficiary, the covered Employee has elected COBRA coverage for himself/herself. The child's COBRA coverage begins when the child is enrolled in the Plan, including when enrolled through a Special Enrollment or an Open Enrollment.

3. A child who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO), received by the Employer during the covered Employee's period of employment with the Employer, is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

If however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law Employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his/her performance of services for the Employer sponsoring the Plan (e.g., self-employed individuals, independent contractors, owners or corporate directors).

WHAT IS A QUALIFYING EVENT? If you are a covered **Employee** you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of either of the following Qualifying Events:

1. your hours of employment are reduced; or

2. your employment ends for any reason other than your gross misconduct.

If you are a covered **spouse** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. your spouse dies;

2. your spouse's hours of employment are reduced;

3. your spouse's employment ends for any reason other than his/her gross misconduct;

4. your spouse becomes entitled to Medicare; or

5. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event for you even though your coverage was reduced or eliminated before the divorce or legal separation.

If you are a covered **Dependent child** of an Employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because of any of the following Qualifying Events:

1. the Employee dies;

2. the Employee's hours of employment are reduced;

3. the Employee's employment ends for any reason other than his/her gross misconduct;

4. the Employee becomes entitled to Medicare;

5. the parents of the Dependent child become divorced or legally separated; or

6. you stop being eligible for coverage under the Plan as a Dependent child.

If an Employee takes FMLA leave and does not return to work at the end of the leave,

the Employee (and the Employee's spouse and Dependent children, if any) will be entitled to elect COBRA if:

1. they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and

2. they will lose Plan coverage within 18 months because of the Employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Employee and Dependents will be entitled to COBRA coverage even if they failed to pay the Employee portion of the contribution for coverage under the Plan during the FMLA leave.

WHEN IS COBRA COVERAGE AVAILABLE? When the Qualifying Event is the end of employment, reduction of hours of employment, or death of the Employee, the Plan will offer COBRA coverage to Qualified Beneficiaries. You need not notify the Employer of any of these three Qualifying Events. An Election Form will automatically be provided.

For the other Qualifying Events (divorce or legal separation of the Employee and spouse, or a Dependent child losing eligibility for coverage as a Dependent child), a COBRA Election Form will be sent to you only if you notify the Employer in writing within 60 days after the date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the Qualifying Event.

WHAT IS THE ELECTION PERIOD AND HOW LONG MUST IT LAST? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his/her right to elect COBRA continuation coverage.

HOW MAY COBRA COVERAGE BE ELECTED? To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator.

Mail, hand-deliver or fax the completed Election Form to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

The Election Form must be completed in writing and mailed, hand-delivered, or faxed to the individual at the address/fax number specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; electronic communications, including e-mail messages; and faxed communications (unless they are on a proper Election Form).

If mailed, your Election Form must be postmarked (and if hand-delivered or faxed, your Election Form must be received by the individual at the address/fax number specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your Qualifying Event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Each Qualified Beneficiary (including a child who is born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage. Covered Employees and spouses (if the spouse is a Qualified Beneficiary) may elect COBRA on behalf of all of the Qualified Beneficiaries, and parents may elect COBRA on behalf of their children.

Qualified Beneficiaries may be enrolled in one or more group health components of the Plan at the time of a Qualifying Event. If a Qualified Beneficiary is entitled to a COBRA election as the result of a Qualifying Event, he/she, may elect COBRA under any or all of the group health components of the Plan under which he/she was covered on the day before the Qualifying Event.

When you complete the Election Form you must notify the Employer if any Qualified Beneficiary has become enrolled under Medicare (Part A, Part B, or both) and, if so, the date of Medicare enrollment. If you become enrolled under Medicare (or first learn that you are enrolled under Medicare) after submitting the Election Form, immediately notify the Employer of the date of your Medicare enrollment at the address specified for delivery of the Election Form.

Qualified Beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are enrolled under Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing

COBRA, he/she becomes enrolled under Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section entitled "When may a Qualified Beneficiary's COBRA continuation coverage be terminated?".

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

WHAT ARE THE MAXIMUM COVERAGE PERIODS FOR COBRA CONTINUATION COVERAGE? The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. For example, if a covered Employee becomes enrolled under Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and Dependent children who lost coverage as a result of his termination can last up to 36 months after the date the Employee became enrolled under Medicare, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes enrolled under Medicare within 18 months **BEFORE** the termination or reduction of hours; or

    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of any other Qualifying Event than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a COBRA covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born, adopted or placed for adoption.

UNDER WHAT CIRCUMSTANCE CAN THE MAXIMUM COVERAGE PERIOD BE EXPANDED? If the Qualifying Event that resulted in your COBRA election was the covered Employee's termination of employment or reduction in hours, an extension of the maximum coverage period may be available if a Qualified Beneficiary is disabled or a second Qualifying Event occurs. You must notify the Employer of a disability or a second qualifying event in order to extend the period of COBRA coverage. **FAILURE TO PROVIDE NOTICE OF A DISABILITY OR SECOND QUALIFYING EVENT WILL ELIMINATE THE RIGHT TO EXTEND THE PERIOD OF COBRA COVERAGE.**

1. **Disability extension of COBRA coverage**. If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the Employer in a timely fashion, all of the Qualified Beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for Qualified Beneficiaries who are receiving COBRA coverage because of a Qualifying Event that was the covered Employee's termination of employment or reduction in hours. The disability must have started at some time before the 61st day after the covered Employee's termination of employment or reduction of hours (this includes disabilities that began prior to the Employee's termination of employment or reduction of hours). The disability must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each Qualified Beneficiary will be entitled to the disability extension if one of them qualifies.

   The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

   a. the date of the Social Security Administration's disability determination;

   b. the date of the covered Employee's termination of employment or reduction of hours; or

   c. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered

Employee's termination of employment or reduction of hours.

You must provide the Social Security Administration's determination notice within 18 months after the covered Employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

2. **Second Qualifying Event extension of COBRA coverage.** An extension of coverage will be available to spouses and Dependent children who are receiving COBRA coverage if a Second Qualifying Event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered Employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a Second Qualifying Event occurs is 36 months. Such Second Qualifying Events may include the death of a covered Employee, divorce or legal separation from the covered Employee, or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a Second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. (This extension is not available under the Plan when a covered Employee becomes enrolled under Medicare.)

   This extension due to a Second Qualifying Event is available only if you notify the Employer in writing of the Second Qualifying Event within 60 days after the later of:

   a. the date of the Second Qualifying Event; or

   b. the date on which the Qualified Beneficiary would lose coverage under the terms of the Plan as a result of the Second Qualifying Event (if it had occurred while the Qualified Beneficiary was still covered under the Plan).

WHAT IS THE COST OF COBRA CONTINUATION COVERAGE? The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health Plan for coverage of a similarly situated Plan Member who is not receiving COBRA coverage (including both Employer and Employee contributions). The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

WHAT ARE THE COBRA CONTINUATION COVERAGE PAYMENT PROCEDURES?
If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the designated

address/fax number, if hand-delivered or faxed.) See the section above entitled “How may COBRA coverage be elected?”

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make the first payment. (For example, your employment terminates on September 30, and you lose coverage on September 30. You elect COBRA coverage on November 15. Your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first premium payment is correct. You may contact the Employer using the contact information provided under the section entitled “How may COBRA coverage be elected?” to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, YOU WILL LOSE ALL COBRA RIGHTS UNDER THE PLAN.

After you make your first payment for COBRA coverage you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each Qualified Beneficiary will be disclosed in the election notice provided to you at the time of your Qualifying Event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month’s COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Following your election of COBRA coverage, you will receive a packet of 12 coupons to submit with your monthly COBRA premium. Periodic notices of payments due for these coverage periods will not be sent (that is, a monthly bill will not be sent to you for your COBRA coverage – it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, YOU WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

All COBRA premiums must be paid by check or money order. CASH WILL NOT BE ACCEPTED.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

COBRA/Eligibility Department
EBSO, Inc.
2145 Ford Parkway, Suite 200
St. Paul, Minnesota 55116-1912
(651) 695-2500 or 1-800-486-7664
Fax number (651)695-1648

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

WHEN MAY A QUALIFIED BENEFICIARY'S COBRA CONTINUATION COVERAGE BE TERMINATED? COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can terminate before the end of the maximum coverage period for several reasons, which are described below.

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

1. timely payment is not made to the Plan with respect to the Qualified Beneficiary. **NOTE:** Invalid payments (i.e., checks returned due to insufficient funds) will result in retroactive termination of coverage.

2. the Employer ceases to provide any group health plan (including successor plans) to any Employee.

3. a Qualified Beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied).

4. a Qualified Beneficiary first becomes enrolled under Medicare benefits (Part A, Part B, or both) after electing COBRA.

5. during a disability extension period, the disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled.

You must notify the Employer in writing within 30 days if, after electing COBRA, a Qualified Beneficiary becomes enrolled under Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the Qualified Beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare enrollment or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the Qualified Beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare enrollment or other group health plan coverage.

If a disabled Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. If the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all Qualified Beneficiaries will terminate (retroactively, if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice that the disabled Qualified Beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Under what circumstances can the maximum coverage period be expanded?")

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Plan Member not receiving COBRA coverage (such as fraud).

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

DOES A QUALIFIED BENEFICIARY HAVE A DUTY TO KEEP THE PLAN INFORMED OF ADDRESS CHANGES? In order to protect your family's rights, you must keep the Employer and the Plan's Claims Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Employer and the Plan's Claims Administrator.

QUESTIONS? If you have questions about your COBRA continuation coverage, you should contact the Employer or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA).

Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

CONTACTS: You may obtain information about COBRA coverage on request from:

1. **The Employer (Plan Administrator):**
   City of San Luis
   1090 E. Union Street
   San Luis, AZ 85349
   928-341-8547

2. **COBRA Administrator:**

   COBRA/Eligibility Department
   EBSO, Inc.
   2145 Ford Parkway, Suite 200
   St. Paul, Minnesota 55116-1912
   (651) 695-2500 or 1-800-486-7664
   Fax number (651)695-1648

The contact information for the Plan may change from time to time. The information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Employer).

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

If you or your Dependent(s) experience any of the following qualifying events, you or your Dependent(s) must notify the Plan Administrator/COBRA Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would end as a result of the qualifying event:

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in "Second Qualifying Event extension of COBRA coverage" (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See "Disability extension of COBRA coverage" for additional notice requirements.

Notice must be made in writing and must include: the name of the Plan; name and address of the Employee covered under the Plan; name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g. divorce decree, birth certificate, disability determination, etc.).

Warning: If your notice is late, or if it is not completed and provided to the Employer as required, no Qualified Beneficiary will be offered the opportunity to elect COBRA coverage.

SECTION F

UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

Continuation

A Plan Member who:

1. Is employed by the Employer;

2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);

3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated,

may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:

1. The twenty four month period beginning on the date on which the Plan Member's absence begins; or

2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

Reinstatement

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;

2. The person makes application for re-employment within the time limit specified by the Employer; and

3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan or waiting period will not be applied, if that exclusion of the Plan or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

SECTION G

GENERAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for the following, ***UNLESS*** specifically stated otherwise in this Plan:

1. **Abortions.** Elective abortion unless carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion, charges incurred to treat those complications will be eligible, whether the abortion was eligible or not.

2. **Absence from Hospital.** Charges made by a Hospital for a period of time when a registered bed patient is absent from the Hospital (e.g., weekend passes).

3. **Acupuncture.** Acupuncture.

4. **After the Termination Date.** Charges after the Plan Member's termination from the Plan.

5. **Alternative Care.** Any service or supply not generally accepted in medical practice in the United States as necessary and appropriate for the diagnosis or treatment of the condition of the patient. For example, the following services shall be considered unaccepted charges for the purposes of this Plan, except as specified in the Covered Expenses:

    a. Aroma therapy;

    b. Bioenergetic therapy;

    c. Biofeedback;

    d. Carbon dioxide therapy;

    e. Chelation therapy (unless due to heavy metal poisoning);

    f. Homeopathy, herbal therapy, or naturopathy;

    g. Megavitamin therapy;

    h. Nutritional based therapy;

    i. Primal therapy;

j. Psychodrama;

k. Vision perception training.

5. **Anonymous support groups**.

6. **Athletic/Health Clubs.** Charges for enrollment in an athletic, health or similar club. Health club memberships and all services provided by a health club facility, air conditioners, room humidifiers, room dehumidifiers, air purifiers, food blenders, exercise equipment, orthopedic or therapeutic mattresses (except hospital-type beds or pressure-relieving mattresses as prescribed by a Physician), home or automobile modification, environmental change, pools, whirlpools, and similar items, even if recommended, ordered or prescribed by a Health Care Professional.

7. **Autopsies** and related charges.

8. **Blood and Blood Donor.** Processing, storage and administration charges related to self-donated blood for potential transfusion to the Plan Member unless incurred after the Plan Member is scheduled for surgery. Services of a blood donor.

9. **Breast Prostheses.** Charges for purchase of breast prostheses, except following a Medically Necessary mastectomy, in which case charges for breast prostheses (one unit per side per Calendar Year per Plan Member) will be covered.

10. **Cardiac Rehabilitation.** Phase III and Phase IV Outpatient cardiac rehabilitation programs. Phase III cardiac rehabilitation begins at the completion of Phase II and may continue for six months or more. The program consists of group education at a community exercise facility, Hospital or clinic, or may be a home exercise program. Phase IV cardiac rehabilitation is a non-medically supervised maintenance program.

11. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for computer, internet, and telephone consultations.

12. **Clergy**. Services of the clergy.

13. **Coma stimulation programs**.

14. **Cosmetic.** Cosmetic Procedures for beautifying purposes unless reconstructive Surgery is necessitated by an accidental Injury or Sickness, or Surgery is needed to restore normal bodily function due to a birth

defect. Breast reduction, unless Medically Necessary or following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy. Breast augmentation, except following a Medically Necessary mastectomy. Reconstruction of the other breast to produce symmetrical appearance will be covered in the case of a unilateral mastectomy.

15. **Court-Ordered Care.** Charges for health care ordered by the court (i.e. court ordered rehabilitative treatment or services), unless otherwise covered under the Plan.

16. **Criminal Activities.** Charges Incurred for treatment of an Injury or Sickness sustained while the Plan Member is participating in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.

17. **Custodial or Maintenance Care.** Custodial Care or domiciliary care, Maintenance Care, rest cures, convalescent care, a place for the aged or a nursing home.

18. **Dental Care.** Dental care (**EXCEPT** for any dental procedures specifically covered by this Plan).

19. **Duplicate**. Duplicate services or supplies.

20. **Durable Medical Equipment.** Durable Medical Equipment, **EXCEPT** as specifically stated otherwise. Replacement or repair of Durable Medical Equipment, prosthetics or orthotics which are stolen; lost; or damaged or destroyed by Plan Member misuse, abuse, or carelessness. Charges for equipment, models, or devices having features over and above that which best meets the Medical Necessity of the Plan Member. Motor vehicles, lifts for wheelchairs, motorized wheelchairs, lifts for scooters or stair lifts. Standard over-the-counter batteries.

21. **Employer Facilities** - Services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Plan Member's employer for the exclusive use of that employer's employees, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Plan Member.

22. **Environmental Change.** Inpatient confinement, when such confinement is primarily for environmental change or rest.

23. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

24. **Excess of Usual, Customary and Reasonable Fee.** For expenses made which are in excess of the Usual, Customary and Reasonable Fee.

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

26. **Experimental.** Charges for services and supplies, which are Experimental/Investigational/Investigative. This exclusion does not apply to covered Routine Patient Costs incurred by a Plan Member who participates in an Approved Clinical Trial. Routine Patient Costs include all items and services consistent with the coverage provided in the plan that is typically covered for a Plan Member who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

27. **Extended Institutional Healthcare Provider**. Extended Institutional Healthcare Provider stays for reasons other than Medical Necessity or the attending Physician has documented that care could be provided in a less acute care setting.

28. **Family Counseling.** Family counseling.

29. **Financial or legal** counseling services.

30. **Foot Care.** Charges related to the following conditions:

    a. Weak, unstable or flat feet, bunions, unless an open cutting operation is performed;

    b. Treatment of corns, calluses or toenails, unless at least part of the nail matrix is removed. This does **NOT** apply when treatment is Medically Necessary due to diabetes or peripheralvascular disease;

    c. Orthopedic shoes, orthotics, arch supports or any such similar device which is not custom made.

31. **Genetic Counseling.** Genetic testing or counseling when it is solely intended to be informational to a Plan Member or when it is used solely to answer questions or clarify issues that would not prevent the deterioration

of a Plan Member's condition and directly impact the treatment being delivered to the Plan Member.

32. **Government.** Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, or local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.

33. **Government Operated Facilities** - Services furnished to the Plan Member in any veteran's Hospital, military Hospital, institution or facility operated by the United States Government, by any state government, by any agency or instrumentality of such government, or any foreign government agency, for which the Plan Member has no legal obligation to pay for services rendered or expenses Incurred, ***EXCEPT*** services incurred and billed for non-service related conditions or for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.

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

35. **Hair Pieces.** Wigs and artificial hair pieces, unless related to a Sickness or Injury covered by this Plan.

36. **Halfway houses, wilderness programs**, group homes, or summer camps.

37. **Hearing Care.** Routine hearing care, except as stated otherwise under Preventive Care.

38. **Hemantinics**.

39. **Home Infusion Services.** Nursing services to administer home infusion therapy the Plan Member or another caregiver can be successfully trained to administer. Home infusion services that do not involve direct Plan Member contact, such as delivery charges and record-keeping.

40. **Hospice Care Services**.

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

42. **Housekeeping or meal services** in the Plan Member's home.

43. **Hypnotism.** Expenses for hypnotism.

44. **Iontophoresis**.

45. **Immediate Family.** Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.

46. **Incurred by Another.** Charges actually Incurred by other persons.

47. **Infirmary**. Infirmary and other healthcare charges from a school or other educational facility.

48. **Infertility/Fertility/Adoption.** Services, drugs, or supplies for the purpose of, or related to the treatment of infertility, including drugs and procedures for the promotion of conception (i.e., assisted reproductive technology (ART) procedures, including sperm banking, artificial insemination, in vitro fertilization (IVGF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), with or without cryopreservation or frozen embryo transfer, Including charges for donor ova or sperm), except the initial examination and tests required to diagnose infertility are Covered Expenses.

    Infertility medications.

    Charges related to or in connection with adoption.

    Charges related to or in connection with surrogacy.

    Lamaze or other childbirth classes.

    Services of a doula.

    Charges for donor ova or sperm unless specifically covered under the Plan.

49. **Inpatient Diagnostic Services, Therapy or Observation.** Charges for Hospital room and board and general nursing care when the Plan Member is admitted primarily for therapy services, diagnostic study or medical observation and if the necessary care can properly be provided on an Outpatient basis.

50. **Marriage/Sex Counseling.** Services or supplies for religious, marital, relationship or sex therapy, counseling or training services.

51. **Massage Therapy**. Charges for massage therapy, rolfing and related services.

52. **Naturopathy**.

53. **No Legal Obligation.** Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.

54. **Not Medically Necessary.** Expenses, of any kind, that are not in connection with or are not Medically Necessary for the treatment of a Sickness or Injury (unless specifically stated otherwise in this Plan).

55. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.

56. **Nurse Midwife.** Delivery services of a certified Nurse Midwife when performed at an unlicensed, unaccredited facility.

57. **Nutritional Supplements.** Outpatient nutritional supplements Including home meals, food, food supplements, infant formulas etc., diets, vitamins, minerals, naturopathic or homeopathic services/substances, other nutritional supplies and over the counter electrolyte supplements, except as required for treatment of inborn errors of metabolism or enteral nutrition via tube.

58. **Over the Counter.** Ordinary over-the-counter items such as cotton balls/swabs, alcohol wipes, bandages and ace wraps. Over the counter home testing and monitoring supplies and devices unless used in the treatment of diabetes.

59. **Patient Education.** Services or supplies for education or training (this exclusion does **NOT** apply to diabetic self-management education programs); social skills training, developmental, educational, scholastic or vocational services or training, including but not limited to: computers and computer software programs, treatment for scholastic improvement, vocational training, visual coordination, motor coordination, and special education for the learning disabled. (**NOTE**: this does ***NOT*** apply to medically necessary therapy).

60. **Penile prosthesis/implants**.

61. **Personal Convenience Items.** Telephone, television, radio, guest trays, personal hygiene or convenience items (other than Hospital admission kits), take-home drugs following discharge from a Hospital, air conditioners, air purifiers, physical exercise equipment, and similar items.

62. **Personal Growth.** Expenses for personal growth/development, hypnotherapy, holistic medicine or other programs with an objective to provide complete personal fulfillment.

63. **Prescription Drugs/Medications.** Outpatient non-legend (over-the-counter) drugs or any Prescription Drug with an over-the-counter equivalent -- regardless of whether there is a prescription, except insulin and nicotine replacement products and those products required by applicable law or regulations.

Phone consultations for the purpose of reviewing records or renewing prescriptions.

The cost of administering Prescription Drugs that are designed for self-administration.

Cosmetic medications.

Anti-wrinkle agents for cosmetic use (e.g., Avage, Renova).

Hair growth stimulants for cosmetic use (e.g., Rogaine).

Tretinoin (e.g., Retin-A) for Plan Members over age 25 for cosmetic purposes.

Hair removal products (e.g., Vaniqa).

Drug efficacy study indicator (DESI) drugs (Prescription Drugs determined by the FDA as lacking substantial evidence of effectiveness).

Emergency contraceptives (e.g., Next Choice, Plan B).

Erectile dysfunction medications (e.g., Viagra, Muse, Yohimbine) except when prescribed for pulmonary artery hypertension, benign prostatic hypertrophy, post-prostatectomy, or Raynaud's disease.

Fluoride supplements; except those required by Healthcare Reform Legislation.

Mineral and nutrient supplements, except when required by law or regulation, Including, fluoride, folic acid and iron).

Pigmenting/depigmenting agents, except psoralen products.

Prescription Drugs labeled “investigational” or “experimental”, except that routine patient costs furnished in connection with an Approved Clinical Trial are covered. Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Replacement of Prescription Drugs that are lost, stolen, damaged or misplaced.

Vitamins, singly or in combination, except prescribed prenatal vitamins, and those required by applicable law or regulation.

Duplicate Prescription Drugs.

64. **Prior to Effective Date.** Charges Incurred prior to a Plan Member’s Effective Date under the Plan.

65. **Private Duty Nursing** services.

66. **Private Room.** Charges for a private room, unless Medically Necessary.

67. **Professional Certifications.** Charges for professional certification, licensure or the like.

68. **Prohibited by Law.** Services that are prohibited by law or regulation.

69. **Recreational Therapy.**

70. **Respite Care.** Respite Care.

71. **Reversal of Sterilization.** Charges for reversal of a sterilization procedure.

72. **Routine**. Any Routine physical examinations or tests not connected with an actual Sickness or Injury except as provided in the Preventive Services subsection of the Plan.

73. **Safety/Sport Related Items –** Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training,

bodybuilding, exercise, fitness, flexibility, diversion therapy, work hardening, or general motivation.

74. **Self-care and self-help training**.

75. **Sensory integration deficit therapy**.

76. **Smoking Cessation. Except** as stated otherwise in the Plan, charges for services, supplies and for smoking cessation programs, or charges related to the treatment of nicotine addiction, including smoking deterrent patches.

77. **Social Worker**. Services of a social worker.

78. **Surrogacy** related to in connection with adoption.

79. **Taxes.** Charges for taxes or surcharges, other than those that a medical facility is legally required to make.

80. **Therapeutic Devices.** Therapeutic devices or appliances [Including needles and syringes (except as diabetic supplies), support garments and other non-medicinal substances, regardless of intended use].

81. **Third Party Exams.** Physical examinations for research or obtaining licensure or insurance.

82. **TMJ.**

83. **Tomosynthesis**.

84. **Transplants.** Charges for services, chemotherapy, supplies, drugs and aftercare for or related to transplants not specifically listed in the Plan.

    High dose chemotherapy with autologous bone marrow transplantation to treat breast cancer.

    Charges associated with the purchase of any organ.

    Services or supplies furnished in connection with the transportation of a living donor.

    Re-transplants within a 365 day period following the original transplant procedure.

    Fetal umbilical cord blood stem cell transplantation.

85. **Transsexual Surgery.** Charges Incurred for transsexual Surgery and for any treatment leading to or in connection with sexual transformation.

86. **Transportation**. Expenses related to transportation to or between healthcare facilities, except as specifically provided under the Ambulance benefit.

Non-Emergency Ambulance services.

87. **Travel.** Travel or accommodations for health, whether or not recommended by a Physician.

88. **Unlicensed Providers.** Any services rendered by unlicensed/uncertified providers, if a license or certificate is required by law where the services are rendered, or services that are outside the scope of the license of a provider. This **exclusion does not apply** to interpreter services if necessary to provide Covered Services to a Plan Member.

89. **Vision.** Expenses for eyeglasses, contact lenses, or for the fitting or examination of such, unless required due to intraocular Surgery or Injury to the eye or as stated otherwise in the Plan. Charges for confinement, treatment, service or materials for Kerato-Refractive Eye Surgery (Surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis Surgery) or LASIK Surgery.

Vision therapy or eye exercises.

Sunglasses (Including any colored or tinted lenses) or safety glasses.

Repair of lenses or frames.

Refractive cataract lenses after cataract surgery.

90. **War/Military Service.** Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared.

91. **Weekend Admission.** Initial Friday, Saturday and Sunday room and board charges Incurred for Hospital confinement which begins on Friday, Saturday or Sunday. This exclusion does not apply to Emergency admissions, pregnancy or scheduled Surgery within the 24-hour period immediately following Hospital admission.

92. **Weight Loss.** Routine treatment of obesity, or weight control counseling (including fees, vitamins, nutrients, supplements, or exercise therapy) and any related diagnostic testing unless necessitated as the result of a specifically identifiable condition of disease etiology, except medical nutrition therapy is a Covered Service. Preventive screening and counseling are Covered Services as listed under Preventive Care benefits.

    Gastric bypass surgery for weight loss (bariatric surgery) regardless of the reason.

93. **Worker's Compensation.** Expenses due to a work-related Injury or Sickness sustained while doing anything pertaining to any occupation or employment for remuneration or profit for which all or part of the expense is payable by workers' compensation or similar law.

Notwithstanding the above exclusions, the Plan will not deny benefits for Covered Expenses for treatment of an Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

SECTION H

PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- **All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)**
- **Outpatient surgery**
- **Special Services, such as podiatry**
- **CT Scans, Pet Scans and MRIs**
- **Home Health Care**
- **Out-of-Network Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

Siarmed: $250 per service or
Out-of-Network (US providers): 40% of the total cost of the service.

Please be prepared to supply the following basic information:

1. Patient's name and date of birth
2. Employee's name, address and phone number
3. Physician's name and phone number
4. Name of the Hospital
5. Reason for the hospitalization
6. Date the hospitalization started
7. Employer's I.D. Number.

SECTION I

COMPREHENSIVE MAJOR MEDICAL BENEFITS

UNLESS SPECIFICALLY STATED OTHERWISE THE FOLLOWING SERVICES AND SUPPLIES ARE SUBJECT TO THE DEDUCTIBLE, PAYMENT PERCENTAGES AND MAXIMUM PAYMENT AMOUNTS SHOWN IN THE SCHEDULE OF COVERAGE, TO THE USUAL, CUSTOMARY AND REASONABLE FEE LIMITATION, TO THE GENERAL EXCLUSIONS AND LIMITATIONS, AND TO ALL OTHER PROVISIONS OF THE PLAN. ALL EXPENSES MUST BE INCURRED AS THE RESULT OF AN INJURY OR SICKNESS AND BE RECOMMENDED BY A PHYSICIAN AS MEDICALLY NECESSARY, UNLESS SPECIFICALLY STATED OTHERWISE.

NOTE: Claims may not be received or processed in the same order that a Plan Member has received service. The Deductible and Payment Percentage will be applied to covered services in the sequence that claims are submitted and processed for payment.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your network provider. Their website and telephone number are listed on the back of your ID card.

To the extent an item or service is a Covered Expense under the Plan, and consistent with the Plan's reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan is prohibited from discriminating against a provider based on the provider's license or certification, as long as the provider is acting within the scope of the provider's license or certification under applicable state law.

COVERED EXPENSES

1. **Allergy Testing, Injections and Serum.** Allergy testing, injections and serum when rendered by a Physician or Health Care Professional.

2. **Ambulance Services. This benefit applies to US Providers ONLY**. Emergency transportation by local professional ground or air ambulance service:

   a. From the Plan Member's home, scene of accident or medical Emergency to a Hospital; or

   b. Between Hospitals and/or Skilled Nursing Facility.

   Transportation is limited to the nearest facility equipped to treat the condition.

3. **Anesthetics.** Anesthetics and their administration when rendered in connection with an eligible surgical procedure and when administered by an anesthetist, anesthesiologist, Physician or by a registered nurse (under supervision of a Physician).

4. **Autism**. Charges for the treatment of Autism.

5. **Birthing Centers. This benefit applies to US Providers ONLY**. Charges made by a Birthing Center are covered on the same basis as if the charges had been made by a general Hospital.

6. **Blood Services.** Blood services, including whole blood, blood components, and blood processing administration. The Plan will not pay for the whole blood or blood components when donated or otherwise replaced by or on behalf of the patient.

7. **Circumcisions.** Circumcisions (including Routine circumcisions) and the related charges for all male Plan Members.

8. **Clinical Trial Routine Patient Costs** incurred by a Qualified Individual who participates in an Approved Clinical Trial. If a Plan Member is covered under a Siarmed Plan, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a Siarmed Provider if a Siarmed Provider is participating in the trial and the Siarmed Provider accepts the Qualified Individual as a participant in the trial. However, if a Plan Member is covered under a Siarmed Plan, and the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by an Out-of-Network US provider or there is no Siarmed Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then Routine Patient Costs will be covered as if provided by a Siarmed Provider.

   For the purpose of this Benefit, the following definitions apply:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and (2) is one of the following:

a. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   i. The National Institutes of Health.
   ii. The Centers for Disease Control and Prevention.
   iii. The Agency for Health Care Research and Quality.
   iv. The Centers for Medicare & Medicaid Services.
   v. A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses i) through iv) above or the Department of Defense or the Department of Veterans Affairs.
   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   vii. Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      a) The Department of Veterans Affairs
      b) The Department of Defense
      c) The Department of Energy; or

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

c. The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means a Plan Member who meets the following conditions:

a. The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.

b. Either:
   i. The referring health care provider has concluded that the Plan Member's participation in the Clinical Trial would be appropriate based upon the Plan Member meeting the conditions described in paragraph a. above; or
   ii. The Plan Member provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Plan Members meeting the conditions described in paragraph a. above.

Routine Patient Costs means all items and services that are typically covered by the Plan for a Qualified Individual who is not enrolled in a Clinical Trial. Routine Patient Costs do not include:

a. The investigational item, device, or service, itself;

b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

9. **Corneal grafts/Sclera shells.** Charges in relation to corneal grafts, and, for aphakic patients, soft lenses or sclera shells intended for use as corneal bandages.

10. **Dental Services.** This is not a comprehensive dental plan. Covered Services under the Plan include only the following dental services or oral maxillofacial services that relate to a Plan Member's medical condition:

a. Treatment of acute, accidental, traumatic Injuries to sound, natural teeth (including replacement of avulsed teeth due to traumatic complications) or jaws. Coverage is for an Injury that results from external trauma to face and mouth only, not for cracked or broken teeth which result from biting or chewing.

   The following are Covered Services under the Plan only if they are a direct result of the Injury:
   i. dental implants;
   ii. orthodontia;

iii. fixed or removable dental prosthetic devices, Including crowns, bridges, and dentures;
iv. corrections of malocclusions.

b. Coverage for oral surgery is limited and includes the following Covered Services under the Plan:

i. Oral surgical treatment of, and orthodontic services related to the management of cleft lip or cleft palate for Dependents up to age 18.

The following are Covered Services under the Plan only if they are a direct result of the cleft lip or cleft palate:

- dental implants;
- orthodontia (If a Dependent child covered under the Plan is also covered under a dental plan which includes orthodontic services, that dental plan shall be considered primary for the necessary orthodontic services.);
- fixed or removable dental prosthetic devices, Including crowns, bridges, and dentures;
- or corrections of malocclusions.

ii. Oral surgery for tumors or cysts of the jawbone or mouth.

The following are Covered Services under the Plan only if they are a direct result of the Illness:

- dental implants;
- orthodontia;
- fixed or removable dental prosthetic devices, Including crowns, bridges, and dentures;
- corrections of malocclusions.

iii. Oral surgery for the removal of bony impacted or partially bony impacted teeth.

iv. Osseous surgery.

11. **Diabetic Education.** Diabetic education and training for self-management programs for Plan Members with diabetes.

12. **Dialysis services.** Charges for dialysis, wherever performed. Charges for supplies and rental of dialysis equipment for home dialysis. This does ***NOT*** include charges for set-up or for furniture.

13. **Foot Conditions**. Charges for treatment for the following foot conditions:

    a. Metatarsalgia or bunions when an open cutting operation is performed;

    b. Corns and calluses or toenails when at least part of the nail root is removed or due to peripheralvascular disease.

14. **Home Health Care Agency. This benefit applies to US Providers ONLY**. Charges made by a Home Health Care Agency for services rendered to a Plan Member due to an Injury or Sickness. Eligible Home Health Care Services begin on the day of initial treatment by a Home Health Care Agency. No amount will be payable for Home Health Care charges unless the following conditions are met:

    a. Continued confinement in a Hospital or Skilled Nursing Facility would have been required if Home Health Care had not been available;

    b. The care at home is Medically Necessary and is not primarily for Custodial Care;

    c. The treatment at home is for the same illness or related condition that made the Hospital and Skilled Nursing Facility confinement necessary;

    d. A Physician must have given a written order for Home Health Care Services.

    Covered Services shall consist of:

    a. Part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN);

    b. Part-time or intermittent services of a home health aide;

    c. Physical, occupational or speech therapy;

    d. Dietary guidance; and

    e. Medical supplies, medical appliances, medical equipment, drugs and/or medications prescribed by the attending Physician. These services may be provided on an Outpatient basis by a Home Health Care Agency, by a Hospital or other facility under an arrangement with a Home Health Care Agency.

Services not covered under the Home Health Care benefit include, but are not limited to: dietitian services, homemaker services, maintenance therapy, dialysis treatment, purchase or rental of dialysis equipment, food or home delivered meals.

Benefits are limited to the maximums set forth in the Schedule of Coverage. A Home Health Care visit shall consist of four hours of service provided through the Home Health Care Agency.

15. **Inpatient Hospital Services.** Hospital charges for Hospital Miscellaneous Expenses, wards, semi-private rooms, cardiac care (including Phase I cardiac rehabilitation while the Plan Member is an Inpatient), Intensive Care Units, nursery rooms for newborn sick and well babies, and private rooms, (provided such confinement is Medically Necessary for the Plan Member's condition). If private room confinement is not Medically Necessary for the Plan Member's condition, the Plan will consider as a Covered Expense an amount equal to the Hospital's semi-private room rate. Charges for private rooms are covered only when Medically Necessary.

    For any covered maternity, the Plan will not limit benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require notification of a length of stay not in excess of the above periods.

    NOTE: When the delivery is outside of the Hospital, the minimum period of Hospital stay begins when the mother or newborn is admitted. The attending Physician will determine whether an admission is in connection with childbirth, and thereby eligible for the minimum length of stay.

16. **Maternity Care.** Maternity Care including Outpatient facility services and Physician medical and surgical services (including office visits) for normal pregnancy, miscarriage, and complications of pregnancy.

    This benefit is available to all Plan Members. Additional benefits may be covered under Preventive Care benefits and are available to all Plan Members.

    Note: Charges Incurred for maternity Inpatient admissions are payable under the Inpatient Hospital services benefit.

    This benefit will also include the services of a certified Nurse-Midwife for care performed under the direction and supervision of a licensed Physician. The supervising Physician shall be identified and the cost of supervision is a

reimbursable expense. Total fees cannot exceed the fee the Physician would have charged had he provided the entire service.

Services provided in connection with the birth of a child who is legally adopted by a Plan Member if all of the following are true:

a. the Dependent was adopted within one year of his/her birth;
b. the Plan Member is legally obligated to pay the costs of the adopted Dependent's birth;
c. the Plan Member has satisfied all applicable limitations set forth in this Plan; and
d. the Plan Member has notified the Employer of the Plan Member's acceptability to adopt children under Arizona law within sixty (60) days of the later of:
   i) receipt of approval from the State, or
   ii) becoming covered under the Plan.

17. **Medical Supplies/Durable Medical Equipment/Prosthetics/Orthotics.** Covered Services under the Plan Include the following types of Medically Necessary Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies, but only if prescribed by a Healthcare Provider for use outside of a Hospital or Skilled Nursing Facility. Covered Services Include:

a. Nebulizer;

b. Breast Pump;

c. Hearing aid (limit of 1 per ear per Plan Member per Calendar Year, only covered in the US at 20% co-insurance); and

Repair of Durable Medical Equipment. Separate charges for the repair of Durable Medical Equipment are Covered Expenses if such equipment is being purchased or is already owned by the Plan Member and repair is necessary to make the equipment serviceable. When repair costs exceed the estimated cost for purchasing or renting the same item for the remaining period of medical need, such excess repair costs are not a Covered Expense. Rental of Durable Medical Equipment while a Plan Member's own Durable Medical Equipment is being repaired is a Covered Expense.

Replacement of Durable Medical Equipment. Durable Medical Equipment that a Plan Member owns, is purchasing, or renting may be replaced in the event of loss, irreparable damage (due to accident or natural disaster) or irreparable wear (i.e., deterioration due to usage over time, not due to a specific event) or when required because of a change in the Plan Member's medical condition or to accommodate bodily growth.

Replacement of Durable Medical Equipment due to irreparable wear is not a Covered Expense during the reasonable useful lifetime of the Durable Medical Equipment; however repair costs up to the estimated cost of replacement of such equipment may be a Covered Expense. This plan reserves the right to re-evaluate Medical Necessity of Durable Medical Equipment associated with a request for replacement of such equipment.

18. **Mental/Nervous Disorders and/or Substance Abuse.** Charges for the treatment of Mental/Nervous Disorders and/or Substance Abuse when recommended by or under the clinical supervision of a licensed Physician or a licensed psychologist. Such treatment must be recognized as appropriate in accordance with broadly accepted standards of medical practice. Charges are payable as shown in the Schedule of Coverage.

    Eligible Inpatient Services: Room & board and miscellaneous charges. Medical services including individual and group psychotherapy, psychological testing, family counseling, and convulsive therapy.

    Day Hospitalization will be payable under this Plan.

    Eligible Outpatient Services: Medical services including individual and group psychotherapy, psychological testing, family counseling, and charges by an approved treatment facility.

19. **Outpatient Facility Services.** Services and supplies received in connection with treatment rendered in the Outpatient department of a Hospital, **Urgent Care Center**, emergency room, emergency care clinic or **Ambulatory Surgical Center**.

20. **Outpatient Prescription Drugs and Medicines**. Outpatient Prescription Drugs and medicines lawfully obtainable upon the written prescription of a Physician.

21. **Oxygen**. Charges for oxygen and other gases and their administration.

22. **Physicians' Services.** The following services and supplies when performed by a Physician or any other properly licensed/certified Health Care Professional, while acting within the scope of his/her license/certificate, are considered Covered Expenses:

    a. Covered Expenses for **visits** made by a Physician to a Plan Member while confined as an **Inpatient** in a covered medical facility. Consultations when requested by the attending Physician, limited to one consultation per day per specialist. This includes Routine pediatric examinations of a newborn sick or well baby.

b. Covered Expenses made by a Physician, for Hospital Outpatient services, **office visits or home visits** for diagnosis and treatment of a specific Injury or Sickness, including voluntary **second or third surgical opinions**; **immunizations and injections of medication** (including the medication) related to a covered Injury or Sickness.

c. **Surgical Services** - Eligible charges are covered for Surgery when performed in a Hospital, Outpatient department of a Hospital, Ambulatory Surgical Center, Physician's office or clinic.

For documented multiple surgical procedures the Plan shall cover the greater surgical procedure at 100% of the Usual, Customary and Reasonable Fee and 50% of the Usual, Customary and Reasonable Fee for each lesser procedure during the same operative session.

NOTE: Charges for the treatment of separate and distinct fractures and surgeries that require the skills of two or more surgeons who have different specialties and when each performs a separate operation are covered at 100% of the Usual, Customary and Reasonable Fee.

Covered Expenses include Hospital pre-operative and post-operative care. Covered Expenses for surgical services include, for example, the following:

i. **Cosmetic Procedures** required as a result of an accidental Injury.

ii. **Breast reconstruction** in connection with a mastectomy, including:

a) Reconstruction of the breast on which the mastectomy was performed;

b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c) Prostheses and physical complications, all stages of mastectomy, including lymphedemas.

iii. **Functional repair** or restoration of any body part when Medically Necessary to achieve normal body function. Charges for reconstructive or cosmetic surgery to restore

bodily function or correct deformity related to a congenital anomaly in a child up to age eighteen (18);

iv. Charges for an **assistant surgeon**.

v. **Voluntary sterilizations**, including all related charges, for all Employees and Dependent spouses.

The word "visit" means a personal interview between the Plan Member and a Physician and does not include telephone calls or interviews in which the Physician does not see the Plan Member for treatment.

23. **Preventive Care Services.** Covered Expenses shall include Routine physical exams (including the related office visit) and the following services:

a. 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 with respect to the individual involved;
b. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
c. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
d. With respect to women, to the extent not described in 1 above, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the HRSA.

Any changes to the recommendations or guidelines referred to above will not be deemed Preventive Services until the first day of the Plan Year beginning on or after the date that is one year after the new recommendation or guideline went into effect.

Covered Services are provided for Preventive Care, Including:

a. Well-baby/child exams and routine periodic preventive exams, Including routine gynecological exams
b. This includes required school and school athletic physicals and camp physicals
c. Preventive care services in conjunction with a routine periodic preventive exam as outlined below
d. Routine immunizations (Including immunizations for foreign travel)

e. Routine hearing exams (limit of one exam per Plan Member per Coverage Year)

f. Routine vision exams (limit of one exam per Plan Member per Coverage Year)

Preventive Care Services	**AGES**											
Covered preventive care services are limited to once per plan member per coverage year unless otherwise indicated.												
All Members	> 5	≥ 11	≥ 12	≥ 18	≥ 19	≥ 20	≥ 45	≥ 50	≥ 55	≥ 60	≥ 75	> 80
Hepatitis C (HCV) screening for people at high risk for infection and one-time screening for people born between 1945 and 1965	X	X	X	X	X	X	X	X	X	X	X	X
Hepatitis B (HBV) screening for people at high risk for infection	X	X	X	X	X	X	X	X	X	X	X	X
Obesity screening and counseling	X	X	X	X	X	X	X	X	X	X	X	X
Chlamydia, gonorrhea and syphilis screening		X	X	X	X	X	X	X	X	X	X	X
High intensity behavioral counseling to prevent sexually transmitted diseases		X	X	X	X	X	X	X	X	X	X	X
Human immunodeficiency virus (HIV) screening		X	X	X	X	X	X	X	X	X	X	X
Human papillomavirus (HPV) screening – once every 3 years beginning at age 30							X	X	X	X	X	X
Depression screening			X	X	X	X	X	X	X	X	X	X
Diabetes screening				X	X	X	X	X	X	X	X	X
High blood pressure screening				X	X	X	X	X	X	X	X	X
Alcohol misuse screening and counseling					X	X	X	X	X	X	X	X
Healthy diet for hyperlipidemia/risk for diet related chronic disease counseling					X	X	X	X	X	X	X	X
Tobacco use behavioral interventions and FDA approved pharmacotherapy for adults who use tobacco					X	X	X	X	X	X	X	X
Lipid panel once every 5 years						X	X	X	X	X	X	X
Aspirin to prevent Cardiovascular Disease (CVD) and colorectal cancer*								X	X	X		
Colorectal cancer screening options (one of the following): • Fecal immunochemical test with flexible sigmoidoscopy every 5 years • Barium enema and flexible sigmoidoscopy every 5 years • CT Colonography every 5 years • Colonoscopy once every 10 years • Stool-based tests: fecal occult blood test, fecal immunochemical test, FIT-DNA (e.g. Cologuard) once per year								X	X	X	X	X
Lung cancer screening with history of smoking									X	X	X	
Herpes zoster/shingles vaccine one time only										X	X	X
Intensive behavioral counseling interventions to promote a healthful diet and physical activity for adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors				X	X	X	X	X	X	X	X	X

Children's Health	Birth	2	3	5	6	7	9	10	11	12	18	19	20	21
Expanded newborn screen (blood)	X													
Phenylketonuria (PKU) once at birth	X													
Evoked otoacoustic emissions (EOAE) once at birth	X													
Prophylactic eye medication for gonorrhea once at birth	X													
Congenital hypothyroidism screening – one time only between birth and 1 year	X													
Sickle cell disease screening – one time only between birth and 1 year	X													
Iron supplements – between 6-12 months*	X													
Autism screening	X	X												
Developmental screening – up to four screenings between birth and 36 months	X	X	X											
Psychosocial/Behavioral assessment – up to four assessments between birth and 36 months	X	X	X											
Pediatric vision screening	X	X	X	X										
Dental caries chemoprevention, oral fluoride*	X	X	X	X	X									
Lead level screening	X	X	X	X	X									
Human Immunodeficiency virus (HIV) screening if at increased risk for HIV	X	X	X	X	X	X	X	X						
Tuberculin skin testing (TB)	X	X	X	X	X	X	X	X	X	X	X			
Hepatitis C virus (HCV) screening for members at high risk	X	X	X	X	X	X	X	X	X	X	X			
Developmental surveillance	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin screening	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Metabolic/Hemoglobin	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Lipid panel		X	X	X	X	X	X	X	X	X	X	X		
Alcohol and Drug use assessment									X	X	X	X	X	X

Men's Health	≥ 18	≥ 45	≥ 65	> 75	≥ 80
Vasectomy sterilization procedure	X	X	X	X	X
Abdominal Aneurysm screening – one time only			X		

Women's Health	≥ 9	≥ 11	≥ 19	≥ 21	> 26	≥ 40	≥ 45	≥ 55	≥ 80
FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity		X	X	X	X	X	X	X	X
Breast cancer chemoprevention counseling and treatment*			X	X	X	X	X	X	X
Counseling and testing related to BRCA with family history			X	X	X	X	X	X	X
Papanicolaou smear (once every 3 years age 40-65)				X	X	X	X	X	
Mammogram						X	X	X	X
Breast cancer screening						X	X	X	X
Osteoporosis screening							X	X	X
Preconception and Prenatal Care									

Folic acid supplements for members planning or capable of pregnancy*
Bacteriuria screening for pregnant female – once per pregnancy
Hepatitis B screening for pregnant female – once per pregnancy
HIV screening for pregnant female
Iron deficiency screening for pregnant female*
RH Incompatibility screening for pregnant female – twice per pregnancy
Syphilis screening for pregnant female
Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for the purchase or rental of breastfeeding equipment, which includes the following: • Purchase of non-hospital grade electric or manual breast pump, once per pregnancy, which includes breast pump supplies for nursing women; • Rental of a hospital grade pump requires a prescription and prior authorization after the 3rd month of rental and may include Member cost-sharing.
Gestational diabetes screening for pregnant women after 24 weeks of gestation
Aspirin to prevent preeclampsia after 12 weeks of gestation in women who are at high risk for preeclampsia *

Immunizations – *Frequency and specific age guidelines in accordance with the Advisory Committee on Immunization Practices*	**≤ 6**	**≥ 7**	**≥ 19**
Diphtheria, Tetanus, Pertussis (Tdap)*	X	X	X
Hepatitis A*	X	X	X
Hepatitis B*	X	X	X
Influenza*	X	X	X
Measles, Mumps, Rubella (MMR)*	X	X	X
Meningococcal*	X	X	X
Pneumococcal*	X	X	X
Inactivated Poliovirus (IPV)*	X	X	
Rotavirus*	X		
Haenophilus Influenza Type B*	X		
Human papillomavirus (HPV)*		X	X
Varicella*		X	X

* Items noted with an asterisk may be covered under the outpatient Prescription Drug benefit.

If a diagnosis is indicated after a routine Preventive Care exam, the exam will be payable under the Routine Preventive Care benefit; however, all healthcare services related to the diagnosis will be payable as any other Illness. Coverage for Plan Members having additional risk factors, exhibiting a Sickness, or symptoms is provided under the Hospital and Physician benefits.

24. **Rehabilitation Facility.** Treatment in a Rehabilitation Facility when the treatment cannot be safely provided on an Outpatient basis. Charges made

by an Inpatient Rehabilitation Facility are covered on the same basis as if the charges had been made by a general Hospital.

25. **Skilled Nursing Facility. This benefit applies to US Providers ONLY.** Charges by a Skilled Nursing Facility for confinement as an alternative to Hospital confinement. The same benefits available in a Hospital are available in a Skilled Nursing Facility when prescribed by the attending Physician and the confinement is due to an Injury or Sickness.

    Benefits are available only as long as necessary for the proper care and treatment of the Plan Member. The Plan may require written certification by the attending Physician as to the continuing need for skilled nursing care.

    Plan Members are eligible for benefits under this provision while recovering from a Sickness or Injury requiring services of an intensity less than those available in an acute general Hospital but greater than those available at the Plan Member's home.

    Benefits are limited to the maximums set forth in the Schedule of Coverage.

26. **Surcharges.** Charges for state imposed surcharges.

    NOTE: If the Plan contains an exclusion for sales tax or other tax, the exclusion shall not be applicable to any surcharges.

27. **Therapies and/or Treatments.** Fees of a Hospital, Physician or Health Care Professional for services used to promote recovery from a Sickness or Injury for the following therapies and/or treatments:

    a. **Cardiac Rehabilitation** – Cardiac rehabilitation is limited to Phase I and Phase II. Phase I cardiac rehabilitation is a medically supervised multidisciplinary program covered under the inpatient Hospital benefit. Phase II cardiac rehabilitation usually begins upon dismissal from the Hospital and may continue for two weeks to three months. It is Physician directed and closely supervised by paramedical personnel. The program components include carefully prescribed exercise, education, counseling and risk-factor modification.

    b. **Chemotherapy** - The treatment of malignant disease by chemical or biological antineoplastic agents.

    c. **Occupational Therapy** - The treatment of a physically disabled Plan Member by means of constructive activities designed and adapted to promote the restoration of the Plan Member’s ability to

satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the Plan Member's particular occupational role.

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. No Benefits are provided for diversional, recreational or vocational therapies (such as hobbies, arts and crafts).

d. **Physical Therapy** - The treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, biomechanical and neuro-physiological principles, and devices. Such therapy is performed to relieve pain, restore maximum function and to prevent disability following Sickness, Injury or loss of a body part.

e. **Radiation Therapy** - The treatment of disease by x-ray, radium, radon, roentgen or radioactive isotope.

f. **Respiratory or Inhalation Therapy** - The treatment of a condition by the administration of medicines, water vapors, gases or anesthetics by inhalation.

g. **Speech Therapy** - Expenses for speech therapy for restorative or rehabilitative speech therapy for speech loss or impairment due to an Injury or Sickness other than a functional nervous disorder, or due to Surgery performed as the result of an Injury or Sickness. If the speech loss is due to a congenital anomaly, Surgery to correct the anomaly must have been performed prior to the therapy.

28. **X-Rays or Laboratory Tests.** X-rays or laboratory tests recommended by a Physician or surgeon for diagnosis of a Sickness or Injury. This includes charges for Pre-admission Testing.

SECTION J

ANNUAL OUT-OF-POCKET MAXIMUM BENEFIT

The Annual Out-of-pocket maximum is the total amount of Covered Expenses that are payable by the Plan Member, during a Calendar Year. It is comprised of the Copay and Coinsurance. The maximum is shown in the Schedule of Coverage.

The Network Annual Out-of-pocket maximum will ***NOT*** be used to satisfy the Out-of-Network Annual Out-of-pocket maximum, and vice versa.

The Annual Out-of-pocket maximum does ***NOT*** include:

1. Charges Incurred for services and supplies which are not covered by the Plan.

2. Charges in excess of the Usual, Customary and Reasonable Fee.

3. Charges Incurred in excess of any maximum benefit listed in the Plan.

4. Any penalty payable by the Plan Member for non-compliance with the Pre-certification provision.

SECTION K

SIARMED

In order to receive benefits under the Siarmed Option, a Plan Member must receive treatment from a Siarmed provider. The Plan offers a higher level of coverage for the expenses provided by Siarmed providers.

A listing of Siarmed providers is available at no charge.

Responsibility for use of Siarmed

It is the Plan Member's responsibility to use Siarmed providers if the Plan Member wants to receive the higher level of benefits provided under this Plan.

The Plan Member is responsible for the difference between the Usual, Customary and Reasonable Fee and billed charges whenever Covered Services under the Plan are provided by a Non- Siarmed healthcare provider.

Healthcare Provider Status. Enrolling in this Plan does not guarantee that a particular Healthcare Provider will remain a Siarmed Network Healthcare Provider or that a particular Healthcare Provider will provide Plan Members with Healthcare Services. Plan Members should verify a Healthcare Provider's status as a Siarmed Network Healthcare Provider each time Healthcare Services are received from the Healthcare Provider.

When a Healthcare Provider is no longer a Siarmed Network Healthcare Provider, Plan Members must either choose to receive Healthcare Services from among the remaining Siarmed Network Healthcare Providers or receive a lower level of benefits as described in the Schedule of Coverage.

SECTION L

CARE PROVIDED BY THE UNITED STATES GOVERNMENT

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other Plans under which an individual is covered so that total benefits available will not exceed 100% of the Allowable Expense for the services. When this Plan pays second, it will pay, with respect to each claim submitted for payment, 100% of Allowable Expenses less whatever payments were actually made by the Plan (or Plans) that paid first.

An “Allowable Expense” means any health care service or expense, including coinsurance, copays or copayment and without reduction for any deductible, that is covered in full or in part by any of the Plan covering the person. Allowable Expenses do not include expenses for services received because of an occupational sickness or injury, or expenses for services that are excluded or not covered under this Plan.

"Claim Determination Period" means the time during any one benefit year when a person is covered and incurs charges for services or supplies covered under this Plan and one other plan.

As each claim is submitted, each plan determines its liability and pays or provides benefits based upon Allowable Expenses incurred during the Claim Determination Period. However, that determination is subject to adjustment as later Allowable Expenses are incurred during the same Claim Determination Period.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;

2. Group practices and other group pre-payment coverage;

3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and

4. Any coverage under governmental programs, such as Medicare, Tricare/CHAMPUS, and any coverage required or provided by any statute, such as no-fault auto insurance.

"Plan" shall not include:

1. School accident type coverage;

2. Hospital indemnity coverage; or

3. Individual insurance coverage.

EFFECT ON BENEFITS

Plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC). Any Plan that does not use these same rules always pays its benefit first.

When two Plans cover the same person, the following order of benefit determination rules establish which Plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until the order of benefits is established. The rules are as follows:

Rule 1: Non-Dependent/Dependent

A. The Plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the Plan that covers the same person as a dependent pays second;

B. There is one exception to this rule. If the individual is a Medicare beneficiary, then, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:

1. Secondary to the plan covering the individual as a dependent; and

2. Primary to the plan covering the individual as other than a dependent (e.g., a retired employee),

then the order of benefits is reversed so that the plan covering the individual as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

Rule 2: Dependent Child Covered Under More Than One Plan.

A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:

1. the parents are married or living together;

2. the parents are not separated (whether or not they ever have been married); or

3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that covered the other parent for the shorter period of time pays second.

C. The word “birthday” refers only to the month and day in a calendar year, not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the Plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the Plan of the spouse of the parent with financial responsibility pays first. This rule applies to plan years commencing after the Plan is given notice of the court decree.

E. If the parents are divorced, separated or not living together (whether or not they have ever been married), and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the Plans of the parents and their spouses (if any) is:

1. The Plan of the custodial parent pays first;

2. The Plan of the spouse of the custodial parent pays second; and

3. The Plan of the non-custodial parents pays third; and

4. The Plan of the spouse of the non-custodial parent pays last.

If the dependent child is covered under a Plan of an individual other than the parents, the order of benefits is determined as if those individuals were the parents of the child. The custody rule is applicable to anyone who has legal custody of the dependent child.

Rule 3: Active/Laid-off or Retired Employee

A. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off or retired, is primary. The Plan covering that same person as a retired or laid-off employee is secondary. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee.

B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

C. This rule does not apply if Rule #1 described above can be used to determine the order of benefits

This rule is applicable only in the rare situations when the same individual is covered under two plans, one as an active employee and the other as a retired or laid-off employee. This rule does not apply to an individual covered under his or her own Plan as either an active, retired, or laid-off employee and also as a dependent under another Plan. In those situations, Rule #1 should be applied.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law (e.g. COBRA) is also covered under another Plan, the Plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the Plan providing continuation coverage to that same person pays second.

B. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

This rule is applicable only to the rare situations when an individual is covered under both COBRA and non-COBRA plans as other than a dependent, or as a dependent of a individual who is covered under both plans as a non-dependent. In the majority of continuation coverage situations, two employee spouses are involved (one on COBRA and one on the basis as active employment). In this scenario, Rule #1 is applicable.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the Plan that covered the person for the longer period of time pays first; and the Plan that covered the person for the shorter period of time pays second.

Rule 6: None of the Above Rules Apply

If the preceding rules do not apply, the allowable expenses shall be shared equally between the Plans.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF PAYMENT

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

SECTION M

MEDICARE SELECTION PROVISION

If the Employer has **less** than 20 Employees in the current Calendar Year, Medicare coverage is primary (and this Plan will be secondary) for active Employees age 65 or older and their Dependents 65 or older. This Plan will reduce payment by the amount paid or payable by Medicare.

If the Employer had 20 or **more** Employees in the current or preceding Calendar Year, Federal law requires that Medicare coverage be secondary to this Plan. The Plan Member has the option of rejecting this Plan thereby retaining Medicare as his/her primary coverage. If the Plan Member chooses Medicare as primary, the Employer can not provide any supplemental coverage. If the Plan Member rejects coverage under this Plan that choice must be made in writing to the Employer.

Federal law also mandates which plan is primary in the case of certain persons who are totally disabled or have end stage renal disease.

NOTE: This Plan will determine the primary and secondary payment of claims based on the current rules and regulations set forth by Medicare.

SECTION N

GENERAL PROVISIONS

The Plan and The Master Plan Document

The Plan Sponsor has filed the Master Plan Document in the office of the Human Resource Department, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator.

Plan Administrator

The Plan Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Plan Administrator is the Employer.

The construction and interpretation of the Plan are vested with the Plan Administrator, in its absolute discretion, including, without limitation, the determination of benefits, eligibility and interpretation of Plan provisions. The Plan Administrator will endeavor to act, whether by general rules or by particular decisions, so as to treat all persons in similar circumstances without discrimination. All such decisions, determinations and interpretations shall be final, conclusive and binding upon all parties having an interest in the Plan.

Named Fiduciary

The Named Fiduciary is the Plan Administrator and has the authority to control and manage the operation and administration of the program. A participant under the Plan will not receive Plan benefits unless the Plan Administrator determines that the participant is entitled to such benefits.

Claims Administrator

The Claims Administrator will provide technical services in connection with operation of the coverage and performing other functions.

The Plan Is Not An Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Employer with the bargaining representative of any Employees.

Exchange Of Information

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.

2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.

3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include:

    a. Surveys; Quality assurance reviews;

    b. Provider and patient profiles;

    c. Utilization review, and

    d. Other similar analyses.

Alternative Treatment

The Plan Administrator has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Plan Administrator feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Plan Administrator to approve such coverage in the future, nor does it obligate the Plan

Administrator to approve of Alternative Treatment for any other Plan Member. Each case will be decided on its own merits.

Free Choice of Physician

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

Qualified Medical Child Support Orders (QMCSO)

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

"Alternate Recipient" shall mean any child of a Plan Member who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Plan Member's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Plan Member.

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

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

2. Make an administrative determination if the Order is a QMCSO and notify the Plan Member and each affected Alternate Recipient of such determination.

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

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

a. Whether the child is covered under the Plan; and

b. Either the Effective Date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

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

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

A Plan Member may request at any time a copy of QMCSO procedures from the Plan without charge.

Other Service Plan Contracts

If any Plan Member is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

Worker's Compensation Notice

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by worker's compensation insurance.

Erroneous Payment Refund Provision

Covered Expenses are occasionally paid erroneously by the Plan (i.e., paid more than once; incorrectly paid under the Plan's terms, conditions, limitations or exclusions; or conditionally paid pending further review). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon

discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. Neither the Plan nor the Plan Administrator shall have any obligation to make any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan Administrator shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider or another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan Administrator's option, be reimbursed in a lump-sum, time payments or deducted from future claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-10, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any claims not paid in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 ½% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

Conformity With Applicable Law

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

Clerical Error

Clerical errors, such as inaccurate transcription of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Plan Members.

Fraud

The following actions by any Plan Member, or a Plan Member's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for that Plan Member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Member in the Plan;

2. Attempting to file a claim for a Plan Member for services which were not rendered or drugs or other items that were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan; or

4. Providing any false or misleading information to the Plan.

No Waiver

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

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Plan Member.

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

Booklets

The Plan Administrator has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members. The booklet is intended to satisfy any requirements for a Summary Plan Description.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, the application of the Employer for any reinsurance policy, and the individual applications, if any, of the Employees and eligible Dependents, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall not, in any way, change such benefits.

All statements made by the Employer or by a Plan Member shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense of a claim unless they are contained in writing and signed by the Employer or by the Plan Member, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such contest.

Plan Modification and Amendment

The City Manager of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the City Manager. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

Plan Termination

The City Manager of the Company may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

Assignment

The Plan Member's benefit payments may not be assigned except by consent of the Company to other than suppliers of medical services.

Automatic Assignment

All medical expense benefits payable under this Plan shall be paid to the medical service provider, unless the claimant furnishes proof of payment of the medical expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant. The Plan is discharged from liability to the extent of such amounts paid to the claimant for Covered Expenses.

Physical Examination

The Plan at its own expense shall have the right and opportunity to examine any Plan Member, whose Injury or Sickness is the basis of a claim, as often as it may reasonably require while a claim is pending.

Disclosure Of Electronic Protected Health Information ("Electronic PHI") To The Plan Sponsor For Plan Administration Functions

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

1. Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

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

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

Privacy Standards

1. Disclosure of Summary Health Information to the Plan Sponsor.

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes.

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

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);

b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   i. The following Employees or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

      HR Department
      City Manager

   ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

   iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

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

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor.

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

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

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

5. Other Disclosures and Uses of PHI.

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

SECTION O

SUBROGATION/RIGHT OF REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Members, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Member(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage"). Plan Member(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Member(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Member(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Member(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Member shall be a trustee over those Plan assets.

In the event a Plan Member(s) settles, recovers, or is reimbursed by any Coverage, the Plan Member(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Member(s). If the Plan Member(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Member(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Member(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Member(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Member(s) fails to so pursue said rights and/or action.

If a Plan Member(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Member(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Member is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Member(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Member(s) fails to file a claim or pursue damages against:

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

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

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Plan Member(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Member's/Plan Members' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Member are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Member's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Member is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Member(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Member(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Plan Member is a Trustee Over Plan Assets

Any Plan Member who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Member understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.

3. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Member disputes this obligation to the Plan under this section, the Plan Member or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Member, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

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

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

In the event that the Plan Member(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Member(s) and all others that benefit from such payment.

Obligations

It is the Plan Member's/Plan Members' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Member may have against any responsible party or Coverage.

8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

9. In circumstances where the Plan Member is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Member obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Member over settlement funds is resolved.

If the Plan Member(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Member(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Member(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Member's/Plan Members' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Plan Member and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Member's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Member(s) in an amount equivalent to any outstanding amounts owed by the Plan Member to the Plan. This provision applies even if the Plan Member has disbursed settlement funds.

Minor Status

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

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

Language Interpretation

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

Severability

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

SECTION P

CLAIM/APPEAL PROCEDURES

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of health benefits under this Plan.

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, EBSO, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

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

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

Pre-service Claims:

A "Pre-service Claim" arises when there is a claim for a benefit under the Plan and the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" arises when there is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant

or the claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.

Further, if the Plan does not require the claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims:

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

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

Post-service Claims:

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

When Health Claims Must Be Filed

Health claims must be filed with the Claims Administrator within six months of the date charges for the service were Incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Organization in accordance with the Plan's Utilization Review procedures.

However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA, Form UB92 or Form ADA:

1. The date of service;
2. The date the Injury or Sickness began;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges;
7. The name of the Plan and Plan ID #;
8. The name and home address of the Employee;
9. The Employee's social security number;
10. The name and home address of the patient; and
11. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Utilization Review Organization will determine if enough information has been submitted to enable proper consideration of the Pre-service Claim or Pre-service Urgent Claim. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the post-service claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (or by the Utilization Review Organization within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of medical services, are NOT ever considered claims.

Timing of Claim Decisions

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

Pre-service Urgent Care Claims:

If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

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

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

Concurrent Claims:

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

Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.

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

Post-service Claims:

If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Plan Administrator and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

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

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

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

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

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

Appeal of Adverse Benefit Determinations – Internal Review

A. Procedures for Review of Adverse Benefit Determinations

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

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;

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

3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;

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

5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination;

6. For the identity of medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice; and

7. In an Urgent Care Claim, for an expedited review process pursuant to which:

    a. A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

b. All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

B. Requirements for Appeal

The claimant must file the appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an initial adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, claimant may telephone: Appeal Dept. EBSO, Inc. at 800-558-7798. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed and/or faxed to the following number: *Attention: Appeal Dept. c/o EBSO, Inc. 215 Stanford Parkway, Findlay, OH 45840. Fax (419) 423-5834.*

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

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

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

C. Notification of Benefit Determination on Review

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Urgent Care Claims: As soon as possible, taking into account the medical

exigencies, but not later than 72 hours after receipt of the appeal.

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

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

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

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

The Plan Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any medical, dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;

7. A description of any available External Review process and how to initiate an External Review;

8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted.

Appeal of Adverse Benefit Determinations – External Review

A. Overview

If the claim is denied, the claimant may be eligible to have his/her claim reviewed by an Independent Review Organization (IRO) pursuant to a process called "External Review." Generally, External Review is available only after the claim denial has been upheld after the final level of appeal under the Plan. The claimant may, however, in limited circumstances have the right to have the claim reviewed by an IRO prior to exhausting the Plan's appeal process. See **Expedited External Review** for further details.

B. Request for Review

External Review is available only for medical claims (excluding dental and vision) that involve medical judgment (including, for example, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for rescissions of coverage (i.e. retroactive cancellations of coverage because of the Plan Member's fraud or intentional misrepresentation of a material fact regarding eligibility for coverage).

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

A request for External Review must be filed in accordance with the instructions contained in the claimant's appeal denial notice and must be received not later than four months after the date he/she receives the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial 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 the denial 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.

C. Preliminary Review

Within five business days after receiving the claimant's External Review request, the Plan Administrator will complete a preliminary review to determine whether his/her request is complete and eligible for External Review. That preliminary review will determine: whether the claimant was covered under the Plan at the time the item or service was requested or provided; whether the final denial of his/her appeal related to the claimant's failure to meet the Plan's eligibility requirements; whether the claimant exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether the claimant has provided all the information and forms required to process an External Review.

Within one business day after the completion of the preliminary review, the Plan Administrator will notify the claimant of one of the following:

1. That his/her request is complete, but she/he is not eligible for external review. This notice will state the reasons for the ineligibility and provide contact information for the Employee Benefits Security Administration.

2. That his/her request is incomplete, but may still be eligible for external review. This notice will describe the information or materials needed to complete the request. The claimant will be permitted to provide the required information by the later of: (a) the last day of the four month filing period or (b) 48-hours after receipt of the notice.

3. That his/her request is complete and eligible for external review.

D. Referral to IRO

If the claimant's request for External Review is complete and eligible, the Plan Administrator will assign a qualified IRO to conduct the External Review and within five business days after making the assignment will provide the IRO with the documents and information the Plan Administrator considered in making its final appeal denial.

The claimant will have at least 10 days to submit additional information to the IRO. If the claimant submits additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan decides, on reconsideration, to reverse its benefits denial and provide coverage or payment, then the external review can be terminated.

If the Plan does not reverse its determination, the IRO will review all of the information and documents timely received. In reaching a decision the IRO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeal process. In addition to the documents and information provided, the IRO, to the extent the information or documents are available and the IRO considers them appropriate will

consider the following in reaching a decision: the claimant's medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the Plan Administrator, the claimant's treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO must provide written notice to the claimant and the Plan Administrator of the final External Review decision within 45 days after the IRO receives the request for External Review. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

E. Expedited External Review

Under the following circumstances, the claimant may be eligible to file for an expedited External Review:

1. If the claimant receives a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the Plan Administrator would seriously jeopardize the claimant's life or health, or that would jeopardize the claimant's ability to regain maximum function, and the claimant has filed a request for an expedited internal appeal; or

2. If the claimant receives a final appeal denial from the Plan Administrator and: he/she has a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize his/her life or health, or would jeopardize his/her ability to regain maximum function; or if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which the claimant has received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited External Review, the Plan Administrator will complete a preliminary review of the claimant's request in order to determine his/her eligibility for expedited External Review. Immediately after completion of the preliminary review, the Plan Administrator will issue the claimant a written notification of his/her eligibility for expedited External Review. If the claimant's request is complete but not eligible for External Review, the notice will include the reasons for ineligibility. If the claimant's request is incomplete, the notice will describe the information or materials needed to make the request complete and the claimant will have an opportunity to complete the request.

Upon a determination that a request is eligible for expedited External Review, the Plan Administrator will assign an IRO for review and transmit all necessary documents and

information to the IRO. The IRO must provide notice, to the claimant and the Plan Administrator of the final External Review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited External Review.

All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

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