

NOTICE OF REGULAR MEETING

In accordance with §38-431.02 of the Arizona Revised Statutes of the State of Arizona, notice is hereby given to the Employee Benefit Trust Board and to the general public that the Mayor and Trustees of the Employee Benefit Trust Board will hold an Employee Benefits Trust Board Meeting at 5:30 P.M. on June 23, 2021. The meeting will take place at the City Council Chambers, located at 1090 E. Union Street, San Luis, Arizona, 85349.

In accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, the City of San Luis does not discriminate on the basis of disability in the admission of or access to, or treatment of employment in its programs, activities, or services. For information regarding rights and provisions of the ADA or Section 504, or to request reasonable accommodations for participation in City programs, activities or services contact: ADA/Section 504 Coordinator, City of San Luis Human Resources Department, 1090 East Union Street, San Luis, Arizona 85349; (928) 341-8579.

Notice is hereby given that pursuant to A.R.S. §1-602.A.9, subject to certain specified statutory exceptions, parents have a right to consent before the State or any of its political subdivisions make a video or audio recording of a minor child. Meetings of the City Council are audio and/or video recorded, and, as a result, proceedings in which children are present may be subject to such recording. Parents in order to exercise their rights may either file written consent with the City Clerk to such recording, or take personal action to ensure that their child or children are not present when a recording may be made. If a child is present at the time a recording is made, the City will assume that the rights afforded parents pursuant to A.R.S. §1-602.A.9 been waived.

THIS NOTICE IS APPROVED BY:

/s/ Maria Munoz, HR Coordinator

AVISO DE JUNTA REGULAR

De acuerdo con los Estatutos del Estado de Arizona A.R.S. §38-431.02, se le informa a los miembros de la Junta Fiduciaria de Beneficios para Empleados y al público en general que el Presidente y la Mesa Directiva de Fondo de Beneficios Medicos de San Luis, Arizona, tendrán una Junta Regular a las 5:30 P.M. el Junio 23, 2021. La junta se llevará a cabo en la Sala del Cabildo, ubicada en el 1090 E. Union Street, San Luis, Arizona, 85349.

De acuerdo con el Acta de Americanos con discapacidades y la Sección 504 del Acta de Rehabilitación del 1973, la Ciudad de San Luis no discrimina por causa de discapacidad la admisión y acceso a sus programas, actividades, servicios o en el trato en cuanto a empleo. Para mas información referente a derechos y provisiones del Acta de Americanos con discapacidades o Sección 504, o para solicitar adaptaciones que sean razonables para la participación en programas, actividades o servicios de la ciudad, contactar al: Coordinador del Acta de Americanos con discapacidades/Sección 504, Departamento de Recursos Humanos de la Ciudad de San Luis, 1090 Este Calle Unión, San Luis, Arizona, 85349; (928) 341-8579.

Por medio de este aviso y de acuerdo con los Estatutos Revisados del Estado de Arizona, sujeto a ciertas excepciones reglamentarias, los padres de familia tienen el derecho de dar o no dar el consentimiento antes que el Estado o alguna subdivision política grabe a un menor de edad, ya sea en audio o video. Las juntas del Concilio se graban en audio y/o video y como resultado, el hecho de que haya menores presentes puede ser sujeto a que sean grabados. Para que los padres de familia puedan ejercer sus derechos pueden solicitar por escrito con la Secretaria de la Ciudad a tal grabación, o tomar acción personal para asegurarse que su hijo/hija menor no esté presente cuando la grabación se lleve a cabo. Si un menor de edad esta presente en el momento de la grabación, la Ciudad asumirá que los padres de familia están cediendo los derechos sobre una posible grabación de acuerdo con el Estatuto Revisado del Estado de Arizona §1-602.A.9.

ESTE AVISO ES APROBADO POR:

/f/ Maria Munoz, Coordinadora de Recursos Humanos

AMENDED ON 06/21/2021

AGENDA

Regular Meeting

City of San Luis Employee Benefit Trust

Council Chambers – City Hall

1090 E Union Street

San Luis, AZ 85349

Wednesday, June 23, 2021

5:30 P.M.

NOTE: Some members of the Board of Trustees of the City of San Luis Employee Benefit Trust may attend the meeting telephonically. If authorized by majority vote of the Board of Trustees, an executive session will be held immediately following the vote in accordance with A.R.S. §38-431.03(A) and the meeting will be temporarily recessed while the Board retires to executive session which will not be open to the public.

For the safety of the public during the COVID-19 pandemic, members of the public may attend the Employee Benefits Trust Board meeting of June 23, 2021, in person if the 6-foot distance can be maintained, which is 27 people. However, members of the public may listen to the meeting's live audio stream on the City of San Luis' website <https://sanluisaz.gov/listenlive>. Recordings of the meetings will be available on the city's website <https://sanluisaz.gov/listenlive> after the meeting.

Por la seguridad del público durante la pandemia COVID-19, habrá asistencia en persona para los miembros del público en la Junta de Fideicomiso de Beneficios para Empleados del 23 de Junio del 2021, si la distancia de 6 pies puede mantenerse. Sin embargo, los miembros del público pueden escuchar el audio en vivo de la reunión transmitido en el sitio web de la Ciudad de San Luis <https://sanluisaz.gov/listenlive>. Las grabaciones de las reuniones estarán disponibles en el sitio web de la ciudad <https://sanluisaz.gov/listenlive> después de la reunión.

- 1. CALL TO ORDER/ROLL CALL**
- 2. CONSENT AGENDA**
- 2. A. MINUTES OF:**
Regular Meeting held on May 5, 2021
- 3. DISCUSSION AND POSSIBLE ACTION ITEMS:**
- 3. A.** Discussion and possible action on any and all matters regarding the purchase and name change of the third-party administrator, EBSO Inc. to 90 Degrees Benefits, Inc. and adoption of service agreement with 90 Degrees Benefits, Inc. and benefit plans for the Fiscal Year starting July 1, 2021. **(Rob Flunker, President of 90 Degrees Benefits, Inc.)**
- 3. B.** Discussion and possible action on any and all matters regarding the quarterly review of the benefit plan. **(Susan Posada, Broker and Consultant).**
- 3. C.** Discussion and possible action on any and all matters regarding Broker agreement renewal. **(Susan Posada, Broker and Consultant)**

4. ADJOURNMENT

Employee Benefit Trust Board Meeting

2. A.

Meeting Date: 06/23/2021

Summary

MINUTES OF:

Regular Meeting held on May 5, 2021

Attachments

Minutes for meeting held on 05/05/2021

MINUTES

Regular Meeting

City of San Luis Employee Benefit Trust

Council Chambers – City Hall

1090 E Union Street

San Luis, AZ 85349

Wednesday, May 5, 2021

- 1. CALL TO ORDER/ROLL CALL** *Chairman Sanchez called the meeting to order at approximately 5:31 PM*

THOSE PRESENT

Board Member Maria Gonzalez – via zoom

Board Member Gustavo MacGrew – via zoom

Secretary Maria Sabori

Vice-Chairman Emma Torres – via zoom

Chairman Gerardo Sanchez – via zoom

OTHERS PRESENT

City Attorney Kay Macuil

City Administrator Tadeo A De La Hoya

Director of Finance Monica Castro – arrived at approximately 5:46 PM

Broker/Benefits Coordinator Susan Posada

Assistant City Attorney Glenn Gimbut

Benefits Coordinator Maria Munoz

City Clerk Sonia Cornelio

IT Technician Axel Chayra

Acting Clerk of the Board Janet Taylor

2. CONSENT AGENDA

All matters are considered routine by the Employee Benefit Trust Board and will be enacted by one motion. If discussion is desired, that item will be removed from the Consent Agenda and will be considered separately.

2.A. MINUTES OF:

- Regular meeting held on March 10, 2021

MOTION: Chairman Gerardo Sanchez and Vice-Chairman Emma Torres to approve the March 10, 2021 minutes. **Motion passed unanimously.**

The vote went as follows:

Board Member Maria Gonzalez

Aye

Board Member Gustavo MacGrew

Aye

Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

3. DISCUSSION AND POSSIBLE ACTION ITEMS:

3.A. Discussion and possible action on any and all matters regarding Stop Loss Renewal with Symetra Financial. **(Susan Posada, Consultant, and Broker)**

Ms. Posada presented the board a PowerPoint and expressed she was pleased with the final stop/loss report and that it did not come in any higher than expected that it came in at 9.33 percent increase which was good because of the claims that are coming in. The second part of the increase was a 29 percent increase, and they dropped it down to 27 percent. Ms. Posada explained that is not a figure that we pay. The 27 percent is the aggregate coverage. The aggregate coverage is anything above the \$50,000.00. Right now, we have difficulty with the COVID. We have a lot of claims coming in. They can be above or below \$50,000.00. What that means is that is when our overall claims are above a certain amount, then we can be paid an additional amount of up to a million dollars. There is a possibility we can be reimbursed. We won't know until June 30th.

Ms. Posada discussed seeking other bids, which were presented in the PowerPoint. They were higher than we currently have and were not comparable. She recommended the city stay with Symetra.

MOTION: Chairman Sanchez and Vice-Chairman Torres to approve the Stop Loss Carriers proposal for renewal. **Motion passed unanimously.**

The vote was as follows:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Vice-Chair Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

3.B. Discussion and possible action on any and all matters regarding Broker Agreement Renewal which expires on June 30, 2021. **(Susan Posada, Broker, and Consultant)**

Before presenting, Ms. Posada stated that she was able to negotiate the Teledoc price per employee from \$15.00 down to \$13.00.

Ms. Posada began by stating she wanted to ensure that everyone knew what she did and gave an outline of her many duties and tasks. She also mentioned one of those duties included protecting the trust, which could have been lost if Summit filed bankruptcy. She stated the funds have grown in the trust from one million to over four million even after claims have been paid. The reason for that is due to the administration and Ms. Posada consulting and helping guide the board. She discussed the fact that previously if employees went out of town, they had no coverage; she remedied that with an out-of-state network and the Mayo clinic. Ms. Posada also explained that it is not easy to find a third-party administrator that would accept a Mexico network.

Assistant City Attorney Glenn Gimbut stated that before the city had Susan Posada, we had turned everything over to Yuma Insurance and trusted them. That is how we had Summit as a third-party administrator. Mr. Gimbut stated that Susan argues for us, and she fights for us. The first year with Susan, we had a savings of over \$350,000.00 versus what we were paying out before. Glenn also referenced the increase in the trust with the city council making the same contribution every year. Mr. Gimbut discussed the bridge of Obama Care and the Affordable Care Act while trying to maintain a plan in Mexico, which she was able to do.

Ms. Posada stated that she forgot to mention that there has not been a change in the contribution for the last six years and that she has to pay for some of the training videos out of pocket. Ms. Posada stated that she has over 25 years of experience in the industry.

Secretary Maria Sabori stated that when she was with the Human Resources Department for about 13 years and had previously worked with Summit as the broker, they were not involved much didn't have any updates unless we contacted them to come in. We were not notified of how the money was working. We only knew that one million dollars were being managed until we were informed that the money was in a general account. We didn't have a committee then, and now there is more structure. The committee is involved and manages the trust, the funds, and the benefits for employees.

Chairman Gerardo Sanchez stated that he was a council member when they had the other brokers and actually got the experience while recruiting other brokers before they had got Susan. And what they got was a brochure of information saying these are going to be your carriers and these are going to be your providers, this is going to be your quote, and there is no guarantee that next year we are going to have the same numbers. None of the extras, like wellness. They would add those extras for an additional cost. Chairman Sanchez stated that he remembers working with Glenn and working with Council trying to find an affordable plan. What the county had what the City of Yuma, Somerton had was way different. Employees are always concerned about

their premium about paying more, and for the past six years, thanks to Susan and the Council approving the budget, we have been able to maintain at a minimal increase. That is a big plus. The fact that we had 1.4 or 1.2 million dollars in the bank before and now we are close to four million speaks volumes. We are saving money, and we are providing more services. Now we need to look at what the other agencies offer. Do they offer the same benefits as we are getting right now for the price we are paying?

Chairman Sanchez commented that he works for a big hospital, and the benefits the city is receiving are better benefits. The family plan is way lower than what others offer. There is close to a \$400.00 a month difference. And they were not getting Mexico and not being able to go to the gym on the city's tab. Those little things make a difference. My biggest concern is losing stability.

Chairman Sanchez stated that with COVID, a lot of insurance premiums are going to go up. A lot of insurance companies are losing money. People are unemployed and are not paying premiums, they are getting hit right now, and we are not going to see it until next year. Hopefully, when everyone is vaccinated, and everything is stable. If we get a third wave that we are expecting, people are going to have to get treated. Just one COVID patient can cost \$169,000.00. If we are able to maintain the quote we have right now are premiums are stable, and we have been making money for the trust. Things could get more expensive. We have had one fatality, one employee passed away due to COVID he had to be treated, and there were other expenses. We have been very fortunate.

The fact that we were proactive and were able to provide vaccines to our first responders before it was required before everyone had it. That speaks volumes. Thank you, Susan. I am a firm believer in saving money and providing the best benefits for the money we pay. Thank you for the great work you have done over the years, ten years already.

Chairman Sanchez opened the floor to any comments or questions from the board.

Board Member Maria Gonzalez stated she thought they were going into an executive session. Chairman Sanchez responded; that was the next item on the agenda, but you can ask them now or ask them in executive session if you have any questions.

4. EXECUTIVE SESSION

4.A. Discussion and possible action on any and all matters regarding action to hold an executive session pursuant to A.R.S. §§ 38-431.03(A) subsections (3) and (4) for discussion or consultation for legal advice with the City Attorney or attorneys in order to

consider the Trustee's position and instruct the City Attorney or attorneys regarding their position regarding the proposed agreement with Susan Posada Agency, Inc. for brokerage services **(Kay Marion Macuil, City Attorney)**

MOTION: Chairman Gerardo Sanchez and Board Member Maria Gonzalez move to hold an Executive Session pursuant to A.R.S. §§ 38-431.03(A) subsections (3) and (4).
Motion passed unanimously

The vote went as follow:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

ADJOURNMENT

MOTION: Chairman Gerardo Sanchez and Vice-Chairman Emma Torres to adjourn the meeting. **Motion passed unanimously**

The vote went as follows:

Board Member Maria Gonzalez	Aye
Board Member Gustavo MacGrew	Aye
Secretary Maria Sabori	Aye
Vice-Chairman Emma Torres	Aye
Chairman Gerardo Sanchez	Aye

Meeting adjourned at approximately 6:30 PM

5. MOTION TO GO BACK INTO REGULAR SESSION

6. DISCUSSION AND POSSIBLE ACTION ACTION ITEM:

6.A. Discussion and possible action on any and all matters regarding renewal of a broker agreement with Susan Posada Agency, Inc. and possible recommendations to City Council. **(Susan Posada, Broker, and Consultant)**

NO ACTION TAKEN

Employee Benefit Trust Board Meeting

3. A.

Meeting Date: 06/23/2021

Department Head: Maria Munoz, HR Benefits Coordinator, Human Resources Department

Submitted By: Maria Munoz, HR Benefits Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the purchase and name change of the third-party administrator, EBSO Inc. to 90 Degrees Benefits, Inc. and adoption of service agreement with 90 Degrees Benefits, Inc. and benefit plans for the Fiscal Year starting July 1, 2021. **(Rob Flunker, President of 90 Degrees Benefits, Inc.)**

SUMMARY:

The third-party administrator, EBSO, was purchased by the Wisconsin company 90 Degrees Benefits, Inc., which according to the Wisconsin Secretary of State website was incorporated in 1977. The company is also registered in Arizona as an out-of-state corporation. However, the Arizona people who have been working with us are still authorized to enter into agreements in Arizona.

This item is to enter into an agreement with 90 Degrees Benefits, Inc. and to adopt the plans for the fiscal year starting 2021 with 90 Degrees Benefits, Inc. as the third-party administrator.

RECOMMENDATION / SUGGESTED MOTION:

1. I MOVE TO APPROVE THE ADMINISTRATIVE SERVICES AGREEMENT FOR THIRD-PARTY BENEFIT SERVICES WITH 90 DEGREE BENEFITS, INC.

2. I MOVE TO APPROVE THE AUTHORIZATION AND GUARANTEE AGREEMENT FOR AUTOMATED CLEARING HOUSE AUTHORITY SO THAT 90 DEGREE BENEFITS, INC. MAY PROCESS DEBIT AND CREDIT CARD PAYMENTS.

3. I MOVE TO APPROVE THE U.S. MEDICAL PLAN WITH 90 DEGREE BENEFITS, INC. AS THE THIRD-PARTY ADMINISTRATOR.

4. I MOVE TO APPROVE THE U.S. DENTAL PLAN WITH 90 DEGREE BENEFITS, INC. AS THE THIRD-PARTY ADMINISTRATOR.

5. I MOVE TO APPROVE THE MEXICO-ONLY MEDICAL PLAN WITH 90 DEGREE BENEFITS AS THE THIRD-PARTY ADMINISTRATOR.

6. I MOVE TO APPROVE THE MEXICO-ONLY DENTAL PLAN WITH 90 DEGREE BENEFITS AS THE THIRD-PARTY ADMINISTRATOR.

Fiscal Impact

Fiscal Impact:

These agreements are for the authorization and for plan procedures, and not the details of the costs involved. Broker/Consultant Susan Posada presented plan cost estimates for the fiscal year starting July 2021 to both the Trust and the San Luis City Council during the Spring 2021 meetings.

Attachments

Administrative Service Agreement

Authorization and Guarantee Agreement for ACH Authority

US Medical Plan document - July 2021

US Dental Plan Document - July 2021

Mexico Only Medical plan document - July 2021

Mexico Only Dental Plan Document - July 2021

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement and accompanying exhibits and appendices which are attached hereto and incorporated herein (collectively referred to as the “Agreement”) is made and entered into this **1st day of July, 2021** (the “Effective Date”), by and between **City of San Luis Employee Benefit Trust**, duly organized and existing under the laws of the state of Arizona with its principal place of business at 1090 East Union St., San Luis, AZ 85349 (hereinafter referred to as the “Plan Sponsor”) and **90 Degree Benefits, Inc. (formerly EBSO, Inc.)**, a corporation duly organized and existing under the laws of the state of Wisconsin with its principal place of business at 7020 N. Port Washington Rd, Suite 206, Glendale, Wisconsin 53217 (hereinafter referred to as the “Claims Administrator”).

WHEREAS, it is agreed that this Agreement will automatically renew each year unless modified, amended or terminated herein as outlined hereafter;

WHEREAS, the Plan Sponsor is a municipality that sponsors a self-funded employee welfare benefit plan (the “Plan”) within the meaning of the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended if applicable;

WHEREAS, the Plan Sponsor desires to make available a program of health care benefits under the Plan and fund said Plan from general assets of the employer through salary reductions and/or other assets;

WHEREAS, the Plan Sponsor wishes to contract with an independent third party to perform certain services with respect to the Plan as enumerated below;

WHEREAS, the Claims Administrator desires to contract with the Plan Sponsor to perform certain services with respect to the Plan as enumerated below;

WHEREAS, the parties intend that the Claims Administrator shall not be deemed a “fiduciary” of the Plan within the meaning of ERISA (if applicable) and Claims Administrator shall have no discretionary authority or final determinative capability with regard to benefit determinations; and

THEREFORE, in consideration of the premises and mutual covenants contained herein, the Plan Sponsor and the Claims Administrator enter into this Agreement for administrative services for the Plan.

ARTICLE I. DEFINITIONS

For purposes of this Agreement, the following words and phrases have the meanings set forth below, unless the context clearly indicates otherwise and wherever appropriate, the singular includes the plural and the plural includes the singular.

- 1.1 Adjudicate means, with respect to all claims submitted to the Plan, process (electronically or manually) and pay, deny or pend for additional information.

- 1.2 Claim means a request by a Claimant for payment or reimbursement for Covered Services from the Plan.
- 1.3 Claimant means any person or entity submitting expenses for payment or reimbursement from the Plan.
- 1.4 Claims Payment Account means an account established by and owned by the Plan Sponsor for payment or reimbursement for Covered Services, which Account shall be an asset of the Plan Sponsor.
- 1.5 Claims Runout means Claims that are incurred but unreported and/or unpaid as of the effective date of termination of this Agreement.
- 1.6 COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- 1.7 Covered Services means the care, treatments, services, supplies, or amounts described in the Plan Document as eligible for payment or reimbursement from the Plan.
- 1.8 Employer means Plan Sponsor (unless otherwise stated), and any successor organization, subsidiary, or affiliate of such Employer that assumes the obligations of the Employer, the Plan, and this Agreement.
- 1.9 ERISA means the Employee Retirement Income Security Act of 1974, as amended.
- 1.10 Health Care Providers means physicians, dentists, hospitals, or other medical practitioners or medical care facilities that are duly licensed and authorized to receive payment or reimbursement for Covered Services provided under the terms of the Plan.
- 1.11 Paid Claims means claims for benefits solely funded by the Plan Sponsor and submitted for processing to the Claims Administrator and for which payment has been issued to the Claimant or assignee.
- 1.12 Plan means the self-funded employee welfare benefit plan, which is the subject of this Agreement and which the Plan Sponsor has established and maintains pursuant to the applicable Plan Document.
- 1.13 Plan Administrator means the person or organization responsible for the functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services. If a Plan Administrator is not appointed in the Plan Document, then the Plan Administrator is the Plan Sponsor.
- 1.14 Plan Document means the instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of Covered Services, as may be amended from time to time. The term Plan Document includes the Summary Plan Description, unless explicitly stated otherwise.

Summary Plan Description means the document required to be provided to Plan Participants under Section 102 of ERISA (if applicable) that describes the terms and conditions under which the Plan operates. In the event of any conflict or inconsistency between the Summary Plan Description and the Plan Document, the terms of the Plan Document will control, when permitted by law.

- 1.15 Plan Participant is any employee of Employer eligible for enrollment, and his or her covered dependents, who are properly enrolled in and entitled to benefits from the Plan. Persons eligible for enrollment are those who meet the Plan's eligibility requirements.
- 1.16 Plan Sponsor means the organization, person, or entity identified as the Plan Sponsor in the introduction to this Agreement. This term also includes the Plan Sponsor's designee, unless otherwise indicated.
- 1.17 Plan Year means the period of time specified as such in the Plan Document.
- 1.18 Utilization Management means the review and evaluation of medical necessity and appropriateness of the use of health care services, procedures or facilities utilized by a Covered Person under the terms of the Plan, as well as any other services that a vendor of Utilization Management services defines as falling within the scope of this term, upon and after execution of an agreement between the Plan and such Utilization Management vendor.

ARTICLE II. PURPOSE OF AGREEMENT AND RELATIONSHIP OF PARTIES

- 2.1 The purpose of this Agreement is to state the terms and conditions by which the Claims Administrator will provide administrative services to the Plan Sponsor as it relates to administration of the Plan(s).
- 2.2 The parties acknowledge that:
 - (a) This is a contract for administrative services only as specifically set forth herein.
 - (b) The Claims Administrator shall not be obligated to disburse more in payment under this Agreement than the Plan Sponsor shall have made available in the Claims Payment Account.
 - (c) This Agreement shall not be deemed to be a contract of insurance under any laws or regulations. The Claims Administrator does not insure, guarantee or underwrite liability. The Claims Administrator has no responsibility, and the Plan Sponsor has total responsibility, for payment of claims arising under the Plan and all expenses incidental to the Plan.
 - (d) The Plan Sponsor acknowledges and agrees that the Claims Administrator will not be deemed to be a legal or tax advisor as a result of the performance of any of its duties under this Agreement, including but not limited to claims processing, COBRA or HIPAA administration, or payment or calculation of any applicable taxes, fees, or other

assessments. The Claims Administrator makes no representation concerning federal, state, or local laws, rules or regulations applicable to the Plan. The Plan Sponsor must seek its own counsel for legal advice and guidance.

- (e) Except as specifically set forth herein, this Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives and successors; provided, however, neither party may assign this Agreement or any or all of its rights or obligations hereunder (except by operation of law) without the prior written consent of the other, which consent may not be unreasonably withheld.
- (f) The work to be performed by the Claims Administrator under this Agreement may, at its discretion, be performed directly by it or wholly or in part through a subsidiary or affiliate of the Claims Administrator or under an agreement with an organization, agent, advisor, or other person of its choosing. Unless the Plan Sponsor objects to the entity chosen, the Claims Administrator may delegate certain portions of its work under this Agreement to any other entity. The Plan Sponsor retains final authority to decide whether said organization, agent, advisor, or other person may be retained or utilized.
- (g) The Claims Administrator represents that it is duly licensed as a claims administrator to the extent required under applicable law and agrees to maintain such licensure at all times while this Agreement is in effect.
- (h) The Claims Administrator will possess, at all times while this Agreement is in effect, an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its clients.
- (i) The Claims Administrator agrees to comply with any applicable state or federal statutes or regulations regarding its operations.

ARTICLE III. RESPONSIBILITIES OF THE CLAIMS ADMINISTRATOR

The Claims Administrator will provide the following administrative services for the Plan on behalf of the Plan Sponsor:

- 3.1 Administer the enrollment of eligible individuals and termination of Plan Participants as directed by the Plan Sponsor, subject to the provisions of this Agreement.
- 3.2 Maintain Plan records based on eligibility information submitted by the Plan Sponsor as to the dates on which a Plan Participant's coverage commences and terminates.
- 3.3 Maintain Plan records of Plan coverage applicable to each Plan Participant based on information submitted by the Plan Sponsor.
- 3.4 Maintain Plan records regarding payments of Claims, denials of Claims, and Claims pending.

- 3.5 Adjudicate Claims incurred by Plan Participants according to the terms of the Plan Document and this Agreement. These Claims will be adjudicated in accordance with accepted industry practices and the Claims Administrator will use an industry-recognized method of determining usual, customary, and reasonable charges, if and as applicable.
- 3.6 Process with due diligence and according to the terms and conditions of the Plan Document all Claims, requests, information, and other responsibilities consistent with this Agreement as outlined herein , including COBRA and HIPAA administration, as outlined in Exhibit X11.
- 3.7 Unless otherwise stated, adjudicate Claims incurred by Plan Participants according to the terms of the Plan Document as construed by the Plan Sponsor or Plan Administrator. The Claims Administrator shall adhere to the administrative guidelines and standard provisions as set forth in the Plan Document and as established by the Plan Sponsor, unless instructed differently by the Plan Sponsor. Any such instructions given by the Plan Sponsor must be communicated to the Claims Administrator in writing.

If the Plan Administrator directs, in writing, the Claims Administrator to pay a claim not covered by the terms of the Plan, the claim shall be paid outside all terms of such Plan, and the written direction to pay such a claim is hereby deemed to release Claims Administrator from any liability in connection therewith. The Plan Sponsor and the Plan Administrator hereby acknowledge that such payments will not qualify for credit toward excess loss insurance coverage, if any, and further assume all legal responsibilities for such payments.

- 3.8 Unless otherwise stated, claims will be adjudicated in accordance with agreed-upon parameters, set forth within the terms of the applicable Plan Document, including – if applicable – the determination of usual, customary, and reasonable charges.
- 3.9 The Claims Administrator reserves the right to charge an additional administration fee for adjudicating Plan provisions requiring special claims handling or considerable manual intervention. The Claims Administrator reserves the right to acknowledge, the need for additional information within any time-period specified by applicable laws or agreements. If additional information is needed, the Claims Administrator will send through the U.S. Mail to the appropriate persons (with a copy to the Plan Participant) an Explanation of Benefits denying the claim pending receipt of requested information. The fact that a written request for additional information has been made will be shown on the Explanation of Benefits form. When all necessary documents and Claim form information have been received, and if the Claim has been approved, a Claim check or draft shall be remitted on the next dispersal date after funding by the Plan Sponsor and Plan Participants shall be notified in writing through the U. S. Mail of ineligible Claims received, indicating the specific Plan provisions attributable to the declination of the Claims pursuant to the written Claims review and appeal procedure in the Plan.
- 3.10 The Claims Administrator reserves the right to increase the fees outlined within this Agreement in the event that the Plan Sponsor materially alters the Plan Document during the term of this Agreement. A material alteration is one that amends the Plan Document in

such a way that it requires the Claims Administrator to expend additional resources to properly perform its functions under this Agreement. Such increased fee must be agreed upon in writing by both parties; either party reserves the right to terminate this Agreement in accordance with Article VIII if the parties cannot agree on an increased fee.

- 3.11 Provide third-party recovery services, including subrogation and reimbursement, as described within the Plan Document. The Claims Administrator shall perform the necessary services with respect to obtaining recoveries, including, but not limited to, identifying claims, sending questionnaires, providing and receiving documentation, as applicable. The Claims Administrator has the discretion to utilize the services of a third party in connection with such matters. Plan Sponsor acknowledges that waiver or reduction of a recovery may be necessary as a result of the particular facts or law applicable to the recovery. The Claims Administrator shall refer requests for negotiation or waiver of a claim to the Plan Sponsor for final determination. The Claims Administrator reserves the right to retain a nominal percentage of the net recovery to the Plan Sponsor to compensate the Claims Administrator for increased administrative fees associated with ensuring recoveries.

Claim Review and Resolution. Unless otherwise stated, the Claims Administrator will refer any doubtful or disputed claims to the Plan Sponsor for a final decision. In the event that the Claims Administrator makes an initial determination that a claim is not eligible for payment under the Plan, and the claimant (or authorized representative or beneficiary) requests a review of such determination, the Claims Administrator shall refer such request to the Plan Sponsor together with the relevant records in the possession of the Claims Administrator. The Plan Sponsor shall then make a full and fair review of the claim denial as required by law. The Claim Administrator will assist in notifying the claimant in writing of the Plan Sponsors' decision on review in accordance with the time limits and other requirements of applicable law. The Plan Sponsor acknowledges that the Claims Administrator does not represent or warrant that all determinations made by the Claims Administrator will be accurate, and the Plan Sponsor expressly reserves for itself the ultimate authority as to claims determinations.

- 3.12 Notify the Plan Participant if any benefits are denied for services submitted on a Claim form. After receiving a notice of denial, a Plan Participant may appeal to the Claims Administrator in accordance with the provisions of the Plan Document. The Plan Participant may also ask the Claims Administrator to provide the Plan Participant with any records that would aid the Plan Participant in an appeal. The Claims Administrator will review the denial in accordance with the terms of the Plan Document and render a decision. Should the Plan Participant further appeal a decision via an appeal to the Plan Sponsor, the Claims Administrator shall assist the Plan Sponsor by providing to the Plan Sponsor the information necessary properly conduct its review.
- 3.13 In processing Claims in accordance with the Plan Document, the Claims Administrator shall provide notice in writing when a Claim for benefits has been denied, setting forth the reasons for the denial, the right to a full and fair review of the denial under the terms of the

Plan Document and applicable law, and otherwise satisfying applicable regulatory requirements governing notice of a denied Claim.

- 3.14 Process, issue, and distribute Claims checks or drafts that the Claims Administrator determines may be due in accordance with the terms of the Plan Document to Plan Participants, Health Care Providers, or others as may be applicable.
- 3.15 In the event that the Claims Administrator pays a Claim in good faith but in error, the Claims Administrator shall make good faith attempts to recover any overpayments, provided the overpayment exceeds \$50, if applicable. If the Claims Administrator is unable to recover the overpayment, the claim may be referred to a collection agency or other organization. In no event may the Plan Sponsor hold the Claims Administrator liable for reimbursement of overpayments made in error but in good faith by the Claims Administrator, unless specified elsewhere in this Agreement.
- 3.16 If the Plan Sponsor is exempt from the requirement to provide women with no-cost access to contraception, and has accurately completed the EBSA Form 700 and submitted a copy to the Claims Administrator, the Claims Administrator shall keep a record of the form on file for the tenure of this Agreement. If the Plan Sponsor validly completes and submits such form to the Claims Administrator, the Claims Administrator shall ensure that the contraception that the Plan Sponsor is exempted from providing is nonetheless provided to Plan Participants, and the Claims Administrator will not increase the fees charged to the Plan Sponsor in connection with providing such contraception. If the Plan Sponsor is not eligible to self-certify for an exemption to the provision of contraception, the Claims Administrator has no obligation to ensure that the relevant contraception is provided.
- 3.17 Evaluate and process dental claims presented for benefits described in the Plan Document. Claims must be submitted to the Claims Administrator in accordance with the provisions of the Plan Document.
- 3.18 Investigate claims when appropriate. This includes, but is not limited to, referring claims to professional consultants at the expense of Plan. In addition, the Claims Administrator may obtain, to the extent permitted by law, from any provider or from hospitals in which a provider's care is provided, such information and records relating to a Plan Participant as the Claims Administrator may require to make a claim determination. The Plan Sponsor or its designee shall have final authority to authorize or disallow benefit payments.
- 3.19 In accordance with the terms of the Plan Document, coordinate benefit coverage when benefits are being provided under two (2) or more group benefit plans or group health care programs as described in the Plan Document.
- 3.20 Execute the Plan's responsibility, on the Plan's behalf, to return funds to the excess loss carrier if and when reimbursement of funds is received by Claims Administrator and/or the Plan, via subrogation, reimbursement, or other claims recovery; after the excess loss carrier has reimbursed the Plan and in accordance with agreement(s) between the Plan and the approved excess loss carrier, if applicable.

- 3.21 Load eligibility data within 3 business days of receipt. The Claims Administrator will accept emergency additions and/or terminations from the Plan Sponsor on an as-needed basis. The Claims Administrator shall not process claims for any person unless included on the eligibility file or as advised by the Plan Sponsor.
- 3.22 If applicable, all payments for services performed by a Preferred Provider Organization will be made directly to the provider. With regard to services performed by an out-of-Network provider, as defined in the applicable Policy or network agreement, when filing proof of loss, the Plan Participant may request in writing that the payment be made to the provider pursuant to an assignment of benefits. In the event there is not an assignment of benefits, all other payments shall be payable to the Plan Participant, or to the estate, except that if the person is a minor or otherwise not competent to give a valid release, payment may be made payable to his parent, guardian or other person as specified by a valid court order.
- 3.23 Document claim payments made to providers and submit the required applicable tax form for the purpose of reporting to the Internal Revenue Service.
- 3.24 Furnish to any provider or any Plan Participant, on request, a Claim form to make a claim for payment for services under the Plan.
- 3.25 If applicable, apply for, on behalf of the Plan Sponsor, a Health Plan Identifier, as defined and regulated by the Centers for Medicare and Medicaid Services (CMS).
- 3.26 If applicable, apply for and maintain an Other Entity Identifier, as defined and regulated by the Centers for Medicare and Medicaid Services (CMS).
- 3.27 In accordance with the Medicare, Medicaid and SCHIP Extension Act of 2007 (the “Act”), information from Plan Sponsors and Plan participants (“Required Data”) must be reported to Centers for Medicaid and Medicaid Services (“CMS”) in order to identify situations where the Plan is, or has been, a “primary plan” with respect to Medicare coverage. Medicare will provide secondary coverage to working employees age 65 or older who are covered by the Plan, the spouses of participants who are covered under the Plan and are Medicare beneficiaries age 65 or older, Medicare beneficiaries with end stage renal disease, and certain disabled Medicare beneficiaries who are also covered by the Plan. Claims Administrator will electronically file the Required Data with CMS.
- 3.28 When applicable, utilize the Health Plan Identifier assigned to the Plan Sponsor in standard transactions, including any required by applicable federal law or regulations.
- 3.29 The Claims Administrator will notify the Plan Sponsor of the amount required to be prospectively deposited to the Claims Payment Account to pay the Claims liability as these Claims are paid weekly.

OR The Claims Administrator will notify the Plan Sponsor of the amount required to be prospectively deposited to the Claims Payment Account to pay the Claims liability as these Claims occur as outlined above.

- 3.30 Respond to Claims inquiries by a Plan Participant, the estate of a Plan Participant, an authorized member of a Plan Participant's family unit, or an authorized Health Care Provider in accordance with the requirements of Article IX and the Business Associate Agreement that is incorporated herein as Appendix C.
- 3.31 Maintain all patient information and other protected or individually identifiable health or health care information in the strictest confidence in accordance with applicable state and federal laws and any and all regulations issued thereunder, and in accordance with Article IX and the Business Associate Agreement that is incorporated herein as Appendix C.
- 3.32 If requested, capture and provide data for IRS Form 5500 filings to the Plan Sponsor.
- 3.33 Provide a standard set of monthly reports detailing Claims processing for the previous month. Such reports will be provided to the Plan Sponsor within 3 business days following the end of the previous month. Any additional reports not part of the standard reports furnished by the Claims Administrator must be mutually agreed on by the Plan Sponsor and the Claims Administrator, as described in Exhibit V.
- 3.34 Provide the Plan Sponsor with claim activity reports on a monthly basis. Such reports shall be in a PDF format or Excel upon request. Claim activity reports will include current period and year-to-date information and shall include those data elements requested. See Exhibit V for additional information.
- 3.35 The Claims Administrator shall issue identification cards to each individual who enrolls in the Plan, unless otherwise agreed upon by the Claims Administrator and the Plan Sponsor. Such identification cards shall be for the administration of Plan Participants' health care benefits under the Plan only and may state that the Claims Administrator assumes no financial risk with respect to Claims.
- 3.36 Utilization Management Services. As outlined in Exhibit IV, the Claims Administrator will provide Utilization Management services for the Plan, including pre-certification of hospital stays, concurrent review of hospital stays, discharge planning or retrospective reviews, hospital bill audits, large case management, and any other managed care programs as agreed to between the Plan Sponsor and the Claims Administrator.
- 3.37 Maintain a Claim file on every Claim reported to it by Plan Participants. Such files and all Plan-related information shall be made available to the Plan Sponsor for consultation, review, and audit upon reasonable notice and request, during regular business hours on business days and at the office of the Claims Administrator. Any such audit will be at the sole expense of the Plan Sponsor.

- 3.38 Upon termination of this Agreement, all Claim files, reports, magnetic tapes, and Plan-related documentation will be remitted to the Plan Sponsor within twenty (20) days. Requests for any reports after this time will be reviewed by the Claims Administrator and billed at an agreed upon hourly rate. All records will be maintained at the principal administrative office of the Claims Administrator or its secure storage facilities for at least 7 years following the termination of a Plan Year. At the end of the 7 year period or termination of this Agreement, if earlier, the Claims Administrator shall notify the Plan Sponsor that these records will be destroyed unless the Plan Sponsor requests, in writing, that all or some of the records be forwarded to the Plan Sponsor.
- 3.39 The Claims Administrator will review information supplied on a disability claim form, or similar statement, from a Health Care Provider. If a determination is made that the disability is the result of, or compensable under any applicable worker's compensation law(s), the claim will be referred to the Plan Sponsor for action as a worker's compensation claim and treated accordingly. If a determination is made that the disability is a result of, or due to, third party liability, or is the responsibility of another payor, the Claims Administrator will consult the Plan regarding coordination of benefits, reimbursement, and/or subrogation, in accordance with the terms of the applicable Plan Document and this Agreement. The Claims Administrator shall promptly adjust and settle such claims in accordance with accepted industry standards and shall notify the claimant of the disposition of the claim within the time period required by law. The Claims Administrator will request periodic updates from the physician as the condition mandates.
- 3.40 Refer any doubtful or disputed Claims to the Plan Sponsor for a final decision.
- 3.41 Summary of Benefits and Coverage (SBC) preparation. In accordance with PPACA, the Plan Sponsor is required to provide Plan Participants with a Summary of Benefits and Coverage. The Plan Sponsor may elect to have the Claims Administrator provide SBC preparation services. The SBC will be drafted in accordance with the PPACA-mandated form and regulations. If SBC preparation is elected, the Claims Administrator requires a **90** day notice of Plan changes 90 days prior to the applicable plan year.
- 3.42 External Review and Independent Review Organizations (IROs). The Claims Administrator has contracted with Utilization Review Accreditation Commission ("URAC") accredited IROs. The Plan Sponsor may elect to access the existing agreements that the Claims Administrator has negotiated with the IROs.

ARTICLE IV. RESPONSIBILITIES OF THE PLAN SPONSOR

The Plan Sponsor will:

- 4.1 Maintain current and accurate Plan eligibility and coverage records, verify Plan Participant eligibility, and submit this information in a format reasonably acceptable to the Claims Administrator and include the following for each Plan Participant: name, address, Social Security number, date of birth, type of coverage, sex, relationship to employee, changes in

coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan. . The Plan Sponsor assumes the responsibility for the disbursement of benefits by the Claims Administrator in the event of error or neglect on the Plan Sponsor's part of providing eligibility and coverage information to the Claims Administrator, including, but not limited to, failure to give timely notification of ineligibility of a former Plan Participant. The Plan Sponsor will be required to provide documentation of eligibility under the plan to the Excess Loss carrier in the event of a claim or otherwise requested by the Claim Administrator.

- 4.2 Unless otherwise stated, the Plan Sponsor acknowledges that it serves as Plan Administrator and fiduciary (as those terms are defined by ERISA), and shall have discretionary authority and control over the management of the Plan, and sole discretionary authority and responsibility for the administration of the Plan. The Claims Administrator does not serve either as Plan Administrator or as a Named Fiduciary of the Plan. All functions, duties and responsibilities of the Claims Administrator are governed exclusively by this Agreement and the Plan Document. The Plan Sponsor will resolve all Plan ambiguities and disputes relating to the Plan eligibility of a Plan Participant, Plan coverage, denial of Claims, or any other Plan interpretation questions. The Claims Administrator will administer and adjudicate Claims in accordance with the terms of the Plan Document but will have no discretionary authority to interpret the Plan Document. If adjudication of a Claim requires interpretation of ambiguous Plan language, and the Plan Sponsor has not previously indicated to the Claims Administrator the proper interpretation of the language, then the Plan Sponsor will be responsible for resolving the ambiguity or any other dispute. In any event, the Plan Sponsor's decision as to any Claim (whether or not it involves a Plan ambiguity or other dispute) shall be final and binding.

If Plan Sponsor directs the Claims Administrator in writing to pay a claim not covered by the terms of the Plan, it is understood that the claim shall be paid outside all terms of such Plan and will require the completion of an authorization form signed by a Plan fiduciary, and the authorization to pay such a claim is hereby deemed to release the Claims Administrator from any liability in connection therewith. The Plan Sponsor hereby acknowledges that such payments will not qualify for credit toward excess loss insurance coverage, if any, and further assumes all legal responsibilities for such payments.

- 4.3 Conduct and control all enrollment meetings, maintenance of enrollment records, and distribution of enrollment materials. Pertinent enrollment information will be sent to the Claims Administrator every week or as agreed to by and between the parties.

Fund the Claims Payment Account and grant the Claims Administrator drafting authority with respect to such Account. The Claims Administrator shall notify the Plan Sponsor of the amount necessary to pay Claims adjudicated from the previous week and the Plan Sponsor will deposit amounts necessary to pay such claims within 14 business days or as agreed upon by and between the parties of such notification by the Claims Administrator.

In the event the Plan Sponsor fails to provide funds for payment of claims within thirty (30) days of receipt of notice of liability from the Claims Administrator, the Plan Sponsor

acknowledges that the Claims Administrator may notify Plan participants and the U.S. Department of Labor of the Plan Sponsor's inability to fund processed claims. In the event that a delay in funding by the Plan Sponsor causes any discounts to be no longer available, the Plan Sponsor agrees that the Claims Administrator shall have no liability with respect thereto.

- 4.4 The Plan Sponsor represents and agrees that they are only providing Claim Administrator "their" money and not any participant funds.
- 4.5 The Plan Sponsor retains ownership of funds provided to Claim Administrator and that funds remain part of Plan Sponsor's general assets.
- 4.6 The Plan Sponsor acknowledges that Claim Administrator is not taking title to funds. The Plan Sponsor acknowledges that Claim Administrator is holding the funds solely on behalf of the Plan Sponsor.
- 4.7 Not require the Claims Administrator, under any circumstances, to issue payment for Claims, excess loss premiums, or any other costs arising out of the subject matter of this Agreement, unless the Plan Sponsor has previously deposited sufficient funds to cover such payment.
- 4.8 Provide the Claims Administrator with written notice of any and all revisions or changes to the Plan Document as agreed to by the parties.
- 4.9 Provide and timely distribute all notices and information required to be given to Plan Participants, maintain and operate the Plan in accordance with applicable law, maintain all recordkeeping, and file all forms relative thereto pursuant to any federal, state, or local law, unless this Agreement specifically assigns such duties to the Claims Administrator.
- 4.10 Pay any and all taxes, surcharges, licenses, and fees levied by any local, state, or federal authority in connection with the Plan.
- 4.11 Comply with all applicable law and any agreements to which the Plan Sponsor is a party or to which the Claims Administrator is a party on behalf of the Plan Sponsor. Plan Sponsor will provide to Claims Administrator copies of any and all contracts between Plan Sponsor and third parties which could affect the administration of the Plan or payment of benefits, including contracts with managed care networks, utilization management providers, or insurers.
- 4.12 Provide Claims Administrator with any and all Required Data (the class of which may be expanded or clarified in future guidance from the Department of Health and Human Services) necessary to fulfill its obligations under section 3.27, above. Plan Sponsor hereby indemnifies and holds harmless Claims Administrator, its members, employees, contractors, successors and assigns, from any civil monetary penalty or excise tax assessed against Claims Administrator as a result of any failure by Plan Sponsor to compile and provide complete, accurate and updated Required Data on a timely basis. Plan Sponsor's

indemnity obligation under the foregoing sentence shall survive the expiration or termination of this Agreement.

- 4.13 If applicable, apply for and maintain a Health Plan Identifier, as defined and regulated by the Centers for Medicare and Medicaid Services (CMS).
- 4.14 Warrant and represent that the only entities that participate, or will participate, in the Plan are in the Plan Sponsor's controlled group of corporations, as that term is defined within ERISA.
- 4.15 Review the statement for the fees charged by the Claims Administrator as applicable, which has been prepared in accordance with the Fee Schedule and which is attached hereto and incorporated herein and marked as Appendix A.
- 4.16 Maintain excess loss insurance with a carrier, and notify the Claims Administrator of any termination, expiration, lapse, or modification of this insurance, if applicable within 7 days of such event.
- 4.17 If the Plan Sponsor is eligible to self-certify an exemption from contraceptive coverage with EBSA Form 700, the Plan Sponsor shall accurately complete such form and submit a copy to the Claims Administrator, and the Plan Sponsor shall retain a copy of such form for the tenure of this Agreement.
- 4.18 Maintain any fidelity bond or other insurance as may be required by state or federal law for the protection of the Plan and Plan Participants, if applicable.
- 4.19 Not hold the Claims Administrator responsible if the Plan is deemed noncompliant with PPACA or regulations promulgated thereunder as the result of the particular benefits offered within the Plan.
- 4.20 Not copy, sell, transfer, or otherwise use the language in this Agreement to create other documents or for any purposes except those in furtherance of the purposes of this Agreement.

ARTICLE V. ACCOUNTING BOOKS / CLOSING DATE / EXCESS LOSS INSURANCE DEDUCTIBLES

- 5.1 The monthly Closing Date of the Claims Administrator's accounting books shall be five (5) business days prior to the last calendar day of the month, unless the Claims Administrator notifies Plan Sponsor otherwise.
- 5.2 In the month in which Plan Sponsor's excess loss insurance contract expires:
 - (a) Plan Administrator must submit all claims to the Claims Administrator before 10:00 A.M. on the last business day prior to the Closing Date in order to allow the Claims

Administrator sufficient time to process those claims and request funds prior to the Closing Date; and

- (b) Plan Sponsor must have adequate funds posted in the Bank Account on the Closing Date for payment of claims submitted to the Claims Administrator on the last business day prior to the Closing Date as well as for all other claim checks which have not yet cleared the Bank Account.
- (c) If the Plan Sponsor fails to comply with both section 5.2(a) and 5.2(b) above, claims submitted on the last business day prior to the Closing Date shall be subject to the new deductible in the amount specified in the renewed excess loss insurance contract and shall not count towards the current year excess loss insurance deductible.
- (d) All claims received after 10:00 A.M. on the last business day prior to the Closing Date and all claims received on or after the Closing Date shall be subject to the new deductible in the amount specified in the renewed excess loss insurance contract and shall not count towards the current year excess loss insurance deductible.

ARTICLE VI CLAIMS AUDIT

- 6.1 At the Plan Sponsor's expense, and with a minimum of 30 days notices to the Claims Administrator, the Plan Sponsor shall have the right to audit any Claims paid by the Claims Administrator on behalf of the Plan Sponsor on the premises of the Claims Administrator, during regular business hours. The Claims Administrator reserves the right to charge a reasonable fee to the Plan Sponsor for expenditure of time by the any employees of the Claims Administrator in completing any audits.
- 6.2 Any errors identified and/or amounts identified as owed to the Plan Sponsor as the result of the audit shall be subject to review and approval by the Claims Administrator prior to any reimbursements to the Plan Sponsor. Overpayments shall be credited to the Claims Payment Account.
- 6.3 Any and all Claims records or other information reviewed by the Plan Sponsor or any third-party auditor shall be treated as confidential and shall be used strictly within the parameters of the audit. The Plan Sponsor and any third-party auditor shall agree to jointly and severally indemnify and hold the Claims Administrator harmless from any action, cost, expense or liability, including reasonable attorneys' fees, which may arise out of the disclosure of any confidential information obtained through such audit and shall execute an agreement to this effect prior to conducting such audit. This indemnity shall survive termination of this Agreement.

ARTICLE VII. PROPRIETARY INFORMATION

- 7.1 The Claims Administrator agrees to treat all proprietary information concerning the Plan Sponsor's operations and the Plan as confidential.

- 7.2 The Claims Administrator owns and shall own all rights, title and interest in and to the systems, procedures, methodologies and practices used by it in connection with the Claims processing, Claims payment and utilization monitoring functions of the Plan, together with any applicable provider network, the negotiated fees, terms and discounts with providers, Claims processing, Claims history and utilization data and information (collectively, the “Claims Administrator Proprietary Information”), all of which is proprietary, confidential, and a trade secret of the Claims Administrator. The Plan Sponsor shall have no right, title or interest in or to the Claims Administrator Proprietary Information. The Plan Sponsor agrees to treat all Claims Administrator Proprietary Information in a confidential manner.
- 7.3 The Plan owns all rights, title, and interest in and to the underlying Plan data and records of claims of all Plan Participants and Beneficiaries (the “Plan Data”). The Claims Administrator shall have access to and shall maintain all Plan Data while this Agreement is in effect and during any period of Claims Runout. The Claims Administrator shall retain such Plan Data until the Claims Administrator receives a request from the Plan Sponsor for transmittal, or for a period of Seven (7) Years after the date of termination, whichever occurs first. The Plan Sponsor, and the Plan itself, shall have access to all Plan Data and a copy of all Plan Data in a form and format that is mutually agreed upon by the Claims Administrator and the Plan Sponsor, and it shall be delivered to the Plan at no cost upon request, no more than once per year and once upon termination of this Agreement.
- 7.4 Neither party shall disclose proprietary information to any other entity without the prior written consent of the party that holds the right, title and interest in the information. Nothing in this Article shall prohibit the disclosure of any information required by law, but in the event of any such disclosure, the disclosing party shall immediately notify the other party in writing, describing the circumstances of and extent of the disclosure. This provision shall survive termination of this Agreement.

ARTICLE VIII. TERMINATION AND MODIFICATION OF AGREEMENT

- 8.1 At any time during the effective term of this Agreement, either the Plan Sponsor or the Claims Administrator may amend or change the provisions of this Agreement. These amendments or changes must be agreed upon in advance in writing by both the Plan Sponsor and the Claims Administrator. However, in the event of a material alteration to the Plan Document, as provided in Article III, a reasonable fee increase may be effected immediately and without written agreement.
- 8.2 This Agreement may be terminated by either the Plan Sponsor or the Claims Administrator at any time, either upon giving 30 days advance written notice to the other party unless both parties agree to waive such advance notice, or with no notice, as stated below. At the option of the party initiating the termination, the other party may be permitted a cure period (of a length determined by the party initiating the termination) to cure any default. If Plan Sponsor terminates this Agreement prior to the end of the Agreement period, all fees for the remainder of the Agreement period will be due upon termination. However, if Claims Administrator terminates this Agreement, the remaining fees will be waived.

8.3 The Claims Administrator may, at its option, terminate this Agreement upon the occurrence of any one or more of the following events on 60 days advance written notice to the Plan Sponsor:

- (a) The Plan Sponsor fails to fund the Claims Payment Account;
- (b) A temporary or permanent receiver is appointed by any court for all or substantially all of the Plan Sponsor's assets, the Plan Sponsor makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Plan Sponsor and it is not dismissed within 60 days of such filing;
- (c) The Plan Sponsor fails to pay administration fees or other fees for the services performed by the Claims Administrator in accordance with this Agreement and Appendix A;
- (d) The Plan Sponsor engages in any unethical business practice or conducts itself in a manner which in the reasonable judgment of the Claims Administrator is in violation of any federal, state, or other government statute, rule, or regulation.
- (e) The Plan Sponsor, through its acts, practices, or operations, exposes the Claims Administrator to any existing or potential investigation or litigation; or
- (f) The Plan Sponsor permits its excess loss insurance to lapse, whether by failure to pay premiums or otherwise.

8.4 The Plan Sponsor may, at its option, terminate this Agreement upon the occurrence of any one or more of the following events on 60 days advance written notice to the Claims Administrator:

- (a) A temporary or permanent receiver is appointed by any court for all or substantially all of the assets of the Claims Administrator, the Claims Administrator makes a general assignment for the benefit of its creditors, or a voluntary or involuntary petition under any bankruptcy law is filed with respect to the Claims Administrator and it is not dismissed within 60 days of such filing;
- (b) The Claims Administrator engages in any unethical business practice or conducts itself in a manner that the Plan Sponsor reasonably determines to be in violation of any federal, state, or other government statute, rule, or regulation;
- (c) The Claims Administrator, through its acts, practices or operations, exposes the Plan Sponsor to any existing or potential investigation or litigation; or
- (d) The Claims Administrator raises its fees in response to a material alteration to the Plan Document.

ARTICLE IX. CLAIMS RUNOUT

- 9.1 If applicable and as agreed to by and between the parties, the Claims Administrator shall pay the Claims Runout for the agreed upon period as specified in the Run Out Services Agreement. Following termination of this Agreement, the terms of this Agreement shall continue to apply with respect to the processing and payment of such Claims Runout and the any fees due to the Claims Administrator (see Appendix A), including the indemnification provision and the Business Associate Agreement (Appendix C). If stated in Run Out Services Agreement, the Claims Administrator may forward any claims received after the Runout Period to the Plan Sponsor or other person or entity designated by the Plan Sponsor; however, the Claims Administrator shall not be obligated to continue forwarding claims at the end of the Runout Period.
- 9.2 If applicable, and as agreed to by and between the parties, upon termination of this Agreement, fees due to the Claims Administrator applicable to the Claims Runout shall be paid prior to the commencement of the Runoff Period. Any additional services requested by the Plan Sponsor and not specifically addressed in this Agreement may be billed. Any other fees incurred by the Claims Administrator on behalf of the Plan Sponsor will be billed directly to the Plan Sponsor for payment or paid out of the claims account.

ARTICLE X. HIPAA

- 10.1 The Plan Sponsor agrees that the Plan will be in compliance with all requirements involving the use or disclosure of protected health information as provided for in 45 C.F.R. Part 164. The duties and responsibilities of the Claims Administrator in connection with the requirements imposed by HIPAA and regulations promulgated thereunder will be set forth in Appendix C the Business Associate Agreement entered into between the Parties to this Agreement.
- 10.2 In the event the Plan submits claims or eligibility inquiries or any other HIPAA Covered Transaction as defined in 45 CFR Part 160 and 162 to the Claims Administrator through electronic means, the Plan and the Claims Administrator shall comply with all applicable requirements of HIPAA and the Plan and the Claims Administrator shall require any of their respective agents or subcontractors to comply with all applicable requirements of HIPAA.

ARTICLE XI. ADDITIONAL SERVICES

- 11.1 OON Savings Program. If selected by Plan Sponsor for the additional service fee specified in Exhibit A. Claims Administrator may make the OON Savings Program available to the Plan Sponsor. The program provides access to discounted charges from health care providers which are made available to Claims Administrator for use with the employee benefit plans that Claims Administrator administers.
- (a) Benefits Payable. The benefits payable shall be determined based on the discounted charges under the OON Savings Program. If a health care provider participates in a

“managed care network” provided to Plan Sponsor by Claims Administrator, the benefits payable for services rendered by those providers shall be based on the rates set forth in the agreement with the “managed care network” and not based on the discounts available under the OON Savings Program.

- (b) Provider Directories. Provider directories or other listings of the health care providers under this program shall not be provided to the Plan Sponsor.
- (c) Services. The services provided under this program are quantitative only and Claims Administrator’s services under this program do not include credentialing of health care providers or any other quality management activities.
- (d) Termination. Claims Administrator may terminate the OON Savings Program in whole or in part at any time for any reason upon written notice to Plan Sponsor. Plan Sponsor may terminate the program at any time for any reason upon giving Claims Administrator written notice. Claims Administrator shall implement such termination within a reasonable period of time after receiving such notice.

11.2 Claim Editing Service. Claim Administrator will utilize the Claim Editing Organization’s software to identify coding errors, duplicate billings and similarly erroneous claims to generate saving to the plan by identifying and avoiding the payment of such erroneous claims for benefits. If selected by Plan Sponsor the additional service fee is specified in Exhibit A. .

- (a) Program Savings. The Program Savings shall be the total dollar amount of the adjudicated claims or the portion thereof, which were adjusted as a result of the Claim Editing Organization’s software identification of such claims as erroneous.
- (b) Term of Agreement. The Claim Editing program shall be effective only during the term of the Agreement. In the event the Agreement is terminated for any reason prior to the expiration of the term thereof, the Claim Editing program shall terminate simultaneously.
- (c) Disclaimer. Plan Sponsor acknowledges that Claims Administrator makes no express or implied representations or warranties regarding the Claim Editing Software or its performance or the OON Savings Program, if any, to be achieved as a result of the utilization of such software.

ARTICLE XII. MISCELLANEOUS

12.1 This Agreement, together with all addenda, exhibits, and appendices supersedes any and all prior representations, conditions, warranties, understandings, proposals, or other agreements between the Plan Sponsor and the Claims Administrator hereto, oral or written, in relation to the services and systems of the Claims Administrator, which are rendered or

are to be rendered in connection with its assistance to the Plan Sponsor in the administration of the Plan.

- 12.2 This Agreement, together with all addenda, exhibits, and appendices, constitutes the entire Administrative Services Agreement of whatsoever kind or nature existing between the parties.
- 12.3 This Agreement may be executed in two or more counterparts, each and all of which shall be deemed an original and all of which together shall constitute but one and the same instrument.
- 12.4 Neither party may assign any of its rights or obligations under this Agreement without the written consent of the other party.
- 12.5 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.
- 12.6 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.
- 12.7 Exclusivity. The Plan Sponsor warrants that the Claims Administrator will exclusively handle these matters for the Plan Sponsor during the pendency of this Agreement.
- 12.8 Governing Law. This Agreement is entered into and governed by and construed in accordance with the laws of the state of Wisconsin without regard to any applicable conflicting choice of law provisions.
- 12.9 Severability. All provisions of this Agreement are severable, and the unenforceability or invalidity of any of the provisions shall not affect the validity or enforceability of the remaining provisions. The remaining provisions will be construed in such a manner as to carry out the full intention of the parties. Section titles or references used in this Agreement shall not have substantive meaning or content and are not a part of this Agreement.
- 12.10 Dispute Resolution. All disputes under this Agreement shall be settled as follows: Either party may notify the other of the matter in dispute and that it wishes to begin the dispute resolution procedure. Within thirty (30) days after notification, a designated executive of Claims Administrator and a designated executive of Plan Sponsor will meet and confer in an effort to resolve the problem. The parties may, if they wish, agree to mediation or other voluntary form of dispute resolution. If the matter is not resolved within thirty (30) days thereafter (or such further time as they may agree) either party may elect to have the dispute arbitrated pursuant to the rules of the American Arbitration Association. Arbitration may be commenced at any time by either party giving written notice to the other party that such dispute has been referred to arbitration under this Section. The arbitrator shall be selected by the joint agreement of the Plan Sponsor and Claims Administrator, but if they do not

agree within twenty (20) business days after the date of the notice referred-to above, the selection will be made pursuant to the rules maintained by the Association. Any award rendered by the arbitrator will be conclusive and binding upon the parties and is to be accompanied by a written opinion of the arbitrator giving the reasons for this award. This provision for arbitration will be specifically enforceable by the parties. The decision of the arbitrator will be final and binding and there will be no right of appeal. Each party will pay its own expenses of arbitration and the expenses of the parties will be equally shared unless, if in the opinion of the arbitrator, any claim or any defense or objection was unreasonable, in which case the arbitrator may assess, as part of his award, all or any part of the arbitration expenses of the other party (including reasonable attorneys' fees) and of the arbitrator against the party raising such unreasonable claim, defense or objection.

- 12.11 Force Majeure. Neither party will be liable for any failure or delay in performance of its obligations hereunder by reason of any event or circumstance beyond its reasonable control, including but not limited to acts of God, war, riot, strike, labor disturbance, fire explosion, telephone network failure(s), flood or shortage or failure of suppliers. If any delay in performance under this section continues for more than 60 consecutive days, the unaffected party will have the right to terminate this agreement with 60 days prior written notice to the affected party, unless the affected party is able to remedy its circumstances within the 60-day notice period.
- 12.12 Indemnification. In addition to the terms already set forth, each party agrees to indemnify and hold harmless the other party against all claims, demands, costs, expenses (including reasonable attorneys' fees), liabilities, and losses arising under this Agreement where such claims, demands, costs, expenses, liabilities, and losses are caused by acts or omissions of the indemnifying party.
- (a) The Claims Administrator will indemnify, defend, and hold the Plan Sponsor and its respective directors, officers and employees harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, court costs and attorney's fees, that the Plan Sponsor may suffer or incur as a result of any dishonest, fraudulent, grossly negligent, or criminal act or omission of the Claims Administrator or its employees, or by a breach of confidentiality or right of privacy of any Plan Participant by the Claims Administrator except for acts taken at the specific direction of the Plan Sponsor. Should the Claims Administrator be called upon to indemnify the Plan Sponsor, it may at its discretion choose to handle any defense efforts necessary to counter claims against the Claims Administrator and/or the Plan Sponsor which would give rise to, and necessitate, said indemnification. The Claims Administrator shall be entitled to rely, without investigation or inquiry, upon any written communication(s) of the Plan Sponsor or agents of the Plan Sponsor. This indemnity does not extend to any acts or omissions other than those enumerated in this paragraph. This indemnity shall survive termination of this Agreement. The remedy for payments made in error will be to seek recovery from the Plan Participant or the provider of services.

- (b) The Plan Sponsor will indemnify, defend, and hold the Claims Administrator and its respective directors, officers and employees harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, court costs and attorney's fees, that the Claims Administrator may suffer or incur as a result of any dishonest, fraudulent, grossly negligent, or criminal act or omission of the Plan Sponsor or its employees, or by the Plan Sponsor's breach of confidentiality or right of privacy of any Plan Participant except for acts taken at the specific direction of the Claims Administrator. Should the Plan Sponsor be called upon to indemnify the Claims Administrator, it may at its discretion choose to handle any defense efforts necessary to counter claims against the Claims Administrator and/or the Plan Sponsor which would give rise to, and necessitate, said indemnification. The Plan Sponsor shall be entitled to rely, without investigation or inquiry, upon any written communication(s) of the Claims Administrator or agents of the Claims Administrator. This indemnity does not extend to any acts or omissions other than those enumerated in this paragraph. This indemnity shall survive termination of this Agreement.
- 12.13 Damages. In no event shall the Claims Administrator be liable for special or consequential damages, even if the Claims Administrator was advised of, or has agreed to, the possibility of such damages. This provision is controlling over any conflicting language in any agreement between Plan Sponsor and the Claims Administrator.
- 12.14 Survival. The Parties agree that specific Articles shall survive termination of this Agreement.
- 12.15 Integration. The parties acknowledge that they have read this Agreement in its entirety and understand and agree to be bound by its terms and conditions. This Agreement constitutes a complete and exclusive statement of the understanding between the parties with respect to its subject matter. This Agreement supersedes and overrides any and all other prior communications and agreements between the parties, whether written or oral. Any prior agreements, promises, negotiations or representations related to the subject matter not expressly set forth in this Agreement are of no force and effect. This Agreement is intended to work in concert with a Business Associate Agreement entered into by the parties to this Agreement.
- 12.16 Third Party Beneficiaries. The Claims Administrator and the Plan Sponsor specifically acknowledge and agree that no parties shall be third party beneficiaries under this Agreement. The parties further agree that nothing under this Agreement shall impose upon the Claims Administrator any obligation to any other party including, but not limited to, beneficiaries under the Plan or covered employees or their assignees.
- 12.17 Authority. Each party represents and warrants to the other that the signatory identified beneath its name below has the authority to execute this Agreement on its behalf. The parties, intending to be legally bound, have executed and delivered this Agreement as of the date set forth.

ARTICLE XIII. SPECIAL PROVISION FOR CLIENTS WITH INDIANA RESIDENTS

- 13.1 The Commissioner of Insurance is entitled to inspect all books and records of Claim Administrator for the purpose of examinations and audits. Trade secrets contained within those books and records, including the identity and addresses of policyholders and certificate holders, are to remain confidential. However, the commissioner may use that confidential information in proceedings instituted against Claim Administrator.
- 13.2 Any insurer, employer, employee group using the services of the administrator is entitled to inspect the books and records of Claim Administrator to the extent necessary for it to fulfill all of its contractual obligations to insured or covered Plan Members. The right of the insurer, employer, employee group, or other group using the services of Claim Administrator is subject to any restrictions contained in this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective 7/1/2021.

CLAIMS ADMINISTRATOR-90 Degree
Benefits, Inc.

PLAN SPONSOR- City of San Luis
Employee Benefit Trust

BY: _____

BY: _____

PRINTED NAME:

Bruce Flunker

PRINTED NAME:

TITLE: President

TITLE: _____

DATE: _____

DATE: _____

AFFILIATES, AGENTS AND/OR SUBSIDIARIES OF PLAN SPONSOR SUBJECT TO THIS AGREEMENT:

APPENDIX A – FEES & SERVICES

Any Claims Administrator service(s) selected by Plan Sponsor (below), not described in the Administrative Services Agreement, effective as of **July 1, 2021** Appendixes and and/or Exhibits attached thereto, heretofore collectively referred to as the “Agreement”, shall be accompanied by a description of the service, as well as terms and limitations applicable to the service(s). Any such description, manual, or terms applicable to service(s) purchased (below) will be deemed to be part of the Agreement. See the Agreement for additional details. Payment for Claims Administrator services shall be due upon the **1st** day of each month. Funds will be advanced via check, ACH.

Disputes regarding fees, deadlines, and penalties will be resolved in accordance with the terms of the Administrative Services Agreement.

****PEPM=Per employee per month**

Broker Annual Consulting Fee	\$35.00 PEPM

Claim Administrator Fees

Annual Renewal Fee	Waived
Booklets	Actual Printing Cost
Medical	\$24.50 PEPM
Dental (Monthly \$500 Minimum)	\$3.00 PEPM
Surcharge Administration	Included in Administration Fee
Run-Out administration	12 months of run out for 6 months of current administration fees
ID Cards	\$1.50 per card
ACA Reporting	\$3.00 PEPM
Summary of Benefits and Coverage (SBC)	Included in Administrative Fee

90 Degree Benefits Review

Inpatient Review	Included in Administration Fee
Case Management	\$113 per hour

Other Claim Administrator Fees:

1. Reprocessing Fee. In the event a retroactive amendment or the Plan Sponsor's failure to fund claims in a timely manner results in the need to reprocess claims, the Plan Sponsor agrees to pay Claim Administrator's expenses in performing that service.
2. Other Expenses. For any other expenses incurred in connection with assisting the Plan Administrator in administration of the Plan, Claim Administrator agrees to bill such expenses, limited to the actual cost to Claim Administrator, and agrees to allow the Plan Sponsor access to records of said costs.
3. Shared Savings. In the event a Plan participant incurs medical expenses that are not eligible for a discount under the Plan's primary preferred provider or secondary preferred provider (if any), or under any other discount arrangement, Claim Administrator is hereby authorized to negotiate with the provider of services or supplies for a discount or, at its discretion, to use the services of a third party to obtain a discount.
4. Increased Postal Fees. Notwithstanding the fees in effect under this Agreement, should the U.S. postal service institute a postal rate increase during the term of this Agreement, then Claim Administrator shall increase the fees then in effect to cover such increased costs.
5. Plan Amendments. Claim Administrator shall have the right to change its fees upon written notice to the Plan Sponsor if any amendment to the Plan changes the amount or type of processing, services or responsibilities undertaken by Claim Administrator, effective as of the effective date of the amendment.
6. Changes in Law Resulting in Increased Costs. Notwithstanding the fees in effect under this Agreement, should there be a change in any law or regulation that results in increased costs to Claim Administrator, Claim Administrator shall increase its fees to cover such increased costs.

Other Vendor Fees

Healthiest You	\$13.00 PEPM
Out of network claim program (Claim Administrator Uses outside vendors for out-of-network)	N/A
Subrogation	25% if settled, 33.33% if legal Action required
Bank Charges	As appear on bank statement
PPO Access Fee – BCBS of Arizona (US Only)	\$19.25 per employee per month
Siarmed	\$4.25 per employee per month
Secondary PPO Multiplan wrap (US Only)	25% of Savings
Large claim negotiation vendor fee	30% of savings
Language Line (translation for non-English speaking employees)	Actual monthly cost billed by Language Line
Reports upon termination of contract/services	
Standard reports	\$2,500.00 standard termination Packet. If IT programming is Required it will be charged at \$150.00 per hour

Exhibits

Eligibility, Enrollment, Data Exchange & Billing (Exhibit I)	Included
- Eligibility Records Maintenance	Included
- Online Enrollment	Included
- Data Exchanges with Carriers or Other Vendors	Included
Customized Web Portal (Exhibit II)	Included
PPO Access & Administration (Exhibit III)	Included
Utilization Review (Exhibit IV)	Included
Reporting (Exhibit V)	Standard Included
Cost Reduction and Savings Programs (Exhibit VI)	Included
Subrogation (Exhibit VII)	Included
Pharmacy Benefit Management (Exhibit VIII)	Included
Stop-Loss Negotiation & Administration (Exhibit IX)	Included
90 Degree Benefits Healthier You/Disease Mgmt. (Exhibit X)	Not Included
Consumer Benefit Account Administration (Exhibit XI)	Not Included
COBRA Administration (Exhibit XII)	Included in Administration Fee
Run-In Administration (Exhibit XIII)	Not Included
Run-Out Administration (Exhibit XIV)	Included
Plan Document/Summary Plan Description, SBCs (Exhibit XV)	Included
- Printing Costs	Not Included
- Documents Posted on Customized Web Portal	Included
- Bilingual Employee Packets and Plan Information	Not Included
- Employee Booklets	Not Included
- Network Directories	Not Included

- Group ID Cards	Included
Post-Termination Provider-Audit (Exhibit XVI)	Included
ACA Reporting (Exhibit XVII)	Included
Standard Exit Report Package	Included
Enrollment, New Hire, Benefit or Health Events	Included

Service Fees for Prescription Drug Volume Discounts

If any funds are payable as a result of the formulary rebates made available by pharmaceutical drug manufacturers, Claims Administrator will retain 80% of the rebate as a component of its' service fee.

Service Fees for OON Savings Program

The Plan Sponsor will pay Claim Administrator a fee as reflected in Schedule A as a percent of the savings obtained as a result of the OON Savings Program described in the Agreement. Savings obtained shall mean the amount that would have been payable to a health care provider, including amounts payable by both the Participant and the Plan, if no discount were available, minus the amount that is payable to the health care provider, again including amounts payable by both the Participant and the Plan, after the discount is taken.

Enrollment Adjustments and Credits

Plan Sponsor may seek retroactive adjustments for administration fees and/or reinsurance premiums only if such request is made within 90 days of the due date of the monthly payment for which such adjustment is sought, and prior to termination of the agreement. Nothing contained herein shall in any way modify the Plan Sponsor's responsibility to make current monthly payments.

On behalf of Claims Administrator – 90 Degree Benefits, Inc.

Date

On behalf of Plan Sponsor - City of San Luis Employee Benefit Trust

Date

APPENDIX B – DISCLOSURE FORM

Agent (If Applicable): Susan Posada Agency Inc. _____
Claims Administrator: 90 Degree Benefits, Inc.

The Agent and/or Claims Administrator listed above will contract Related Services Agreements in conjunction with the sale of the group policy or policies you have selected to purchase. This arrangement does not limit your Agent and/or Claims Administrator from marketing for other insurance companies or organizations.

The Agent and/or Claims Administrator may be entitled to commissions and/or marketing allowances on such contracts, expressed as a percentage of gross annual premium.

AGENT
[0%] of Specific Premium
[0%] of Aggregate Premium

Claims Administrator
[0%] of the Specific Premium
[0%] of the Aggregate Premium

In addition to commissions, Agent and/or Claims Administrator may receive additional compensation in the form of cash bonus and/or certain travel bonuses awarded by the insurance carrier or other ancillary service providers. The bonus is developed and paid by the carrier or other ancillary service providers based on several aspects of Agent's/Claims Administrator's entire block of business with the carrier or other ancillary service providers.

The undersigned acknowledges receipt of the various proposals and the statement prior to any purchase and approves this transaction on behalf of the Plan without receiving, either directly or indirectly, any personal compensation in connection with the purchase of policies under the Plan.

When Excess Loss Insurance is placed by the broker and not 90 Degree Benefits, Inc., 90 Degree Benefits, Inc. will not be held liable for discrepancies between the Excess Loss contract and the Plan Document.

On behalf of Plan Sponsor - City of San Luis Employee Benefit Trust

Company Name: City of San Luis Employee Benefit Trust

Client/Group Number(s): SLS001

APPENDIX C - BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of the Effective Date by and among Plan, Business Associate and Plan Sponsor. For purposes of this Agreement, all capitalized terms contained in this Agreement, not otherwise defined herein, shall have the meanings ascribed to them in Schedule A, attached hereto and made a part hereof.

R E C I T A L S:

- A.** Business Associate provides Administrative Services to Plan.
- B.** Plan Sponsor sponsors Plan and provides Plan Administrative Services to Plan. In the performance of the Plan Administrative Services, Plan Sponsor requires access to PHI.
- C.** HIPAA Rules and Plan require that Business Associate comply and Business Associate is willing to comply with the HIPAA Rules in connection with the performance of the Administrative Services, all upon the terms and conditions set forth herein.
- D.** Plan also desires that Business Associate disclose and Business Associate is willing to disclose Summary Health Information, enrollment/disenrollment information and PHI to Plan Sponsor and Designated Plan Sponsor Employees upon the terms and conditions set forth herein.

NOW THEREFORE, for and in consideration of the premises, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereby agree as follows:

1. Term. The term of this Agreement shall commence on the Effective Date and shall continue for so long as Business Associate is providing the Administrative Services, unless earlier terminated pursuant to this Agreement.

2. Permitted Uses and Disclosures of PHI on Behalf of Plan. Plan and Business Associate hereby agree that Business Associate may, in the performance of the Administrative Services, use and disclose PHI to health care providers, other business associates of Plan, agents or subcontractors of Business Associate, and others, in any manner Plan would be permitted or required to use and disclose PHI under the HIPAA Rules if Plan were performing the Administrative Services including without limitation, for Treatment, Payment and Health Care Operations. Business

Associate may de-identify PHI in accordance with § 164.514 of the HIPAA Rules, and such de-identified information is not subject to the terms of this Agreement. Business Associate recognizes and agrees that when acting as a business associate hereunder, Business Associate is obligated by law to comply with the applicable provisions of the HIPAA Rules.

3. Permitted Uses and Disclosures of PHI for Business Associate Operations. Plan and Business Associate hereby agree that Business Associate may use PHI, if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate. Business Associate may disclose PHI for its proper management and administration or to carry out its legal responsibilities if the disclosure is required by law or if Business Associate obtains reasonable written assurances from the Person to whom PHI will be disclosed that: (a) PHI will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to such Person or only as required by law; and (b) such Person will notify Business Associate of any instances of which it becomes aware in which the confidentiality of PHI was breached. Business Associate may also use and disclose PHI to provide Data Aggregation services relating to the Health Care Operations of Plan.

4. Disclosure of Summary Health Information and Enrollment Information to Plan Sponsor. Plan hereby authorizes and directs Business Associate to disclose Summary Health Information and information about an individual's enrollment in or disenrollment from Plan as requested from time to time by Plan Sponsor. In disclosing Summary Health Information to Plan Sponsor hereunder, Plan hereby authorizes and directs Business Associate to, and Plan Sponsor hereby agrees Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor:

A. Plan Sponsor shall only request Summary Health Information for the purpose of (i) obtaining premium bids from health insurers for providing health insurance coverage under Plan; or (ii) modifying, amending, or terminating Plan.

B. Plan has included all necessary statements in its notice of privacy practices required by the HIPAA Rules to permit Plan and Business Associate to disclose Summary Health Information to Plan Sponsor.

5. Disclosure of PHI to Designated Plan Sponsor Employees. Plan hereby authorizes and directs Business Associate to disclose PHI to Designated Plan Sponsor Employees as requested from time to time by Designated Plan Sponsor Employees. If requested by Plan Sponsor, Plan also authorizes and directs Business Associate to give Plan Sponsor electronic access to PHI for use by Designated Plan Sponsor Employees. In disclosing PHI to Designated Plan Sponsor Employees hereunder, Plan hereby authorizes and directs Business Associate, to, and Plan Sponsor hereby agrees Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor:

A. The Privacy Plan Amendment has been duly adopted by all necessary or

appropriate action of Plan and Plan Sponsor and is, or will be, in full force and effect on the Effective Date. Plan has included all necessary statements in its notice of privacy practices required by the HIPAA Rules to permit Plan and Business Associate to disclose PHI to Designated Plan Sponsor Employees. Plan Sponsor and Plan shall promptly notify Business Associate of any modification or amendment to the Privacy Plan Amendment. Plan Sponsor and Plan shall also promptly notify Business Associate of any additions to or deletions from the Designated Plan Sponsor Employees.

B. Plan Sponsor shall ensure that only Designated Plan Sponsor Employees shall use or have the opportunity to use, any electronic access to PHI provided to Plan Sponsor by Business Associate hereunder.

C. On and after the Effective Date, Plan and Designated Plan Sponsor Employees will comply in all respects with the HIPAA Rules and the Privacy Plan Amendment that are applicable to this Agreement.

D. Designated Plan Sponsor Employees shall request only PHI from Business Associate that is the minimum necessary as required by the HIPAA Rules to perform the Plan Administrative Services.

6. **Disclosures of PHI to Privacy Officer.** Plan hereby authorizes and directs Business Associate to disclose PHI to the Plan's Privacy Officer for purposes of implementing the HIPAA Rules and as may be requested by the Privacy Officer from time to time. In disclosing PHI to the Plan's Privacy Officer, Plan hereby authorizes and directs Business Associate to, and Plan Sponsor hereby agrees Business Associate may, rely solely upon the following representations, warranties and agreements of Plan and Plan Sponsor: All necessary actions under the HIPAA Rules have been performed to permit the Plan's Privacy Officer to have access to the PHI as described herein.

7. **Minimum Necessary.** Business Associate will, in its performance of the functions, activities, services, and operations specified above, make reasonable efforts to use, to disclose, and to request only the minimum amount of PHI reasonably necessary to accomplish the intended purpose of the use, disclosure, or request. Business Associate and Plan acknowledge that the phrase "minimum necessary" shall be interpreted in accordance with the HIPAA Rules. Plan shall notify Business Associate of:

(i) any limitation(s) in the notice of privacy practices of Plan under the HIPAA Rules, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

(ii) any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI; and

(iii) any restriction on the use or disclosure of PHI that Plan has agreed to or is required to abide by under §164.522 of the HIPAA Rules, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

Furthermore, Plan agrees to notify Business Associate prior to Plan's agreement to any of the forgoing changes, limitations, revocations, or restrictions.

8. Unauthorized Use or Disclosure. Business Associate shall not use or further disclose PHI other than as permitted by this Agreement or as required by law.

9. Privacy and Security Safeguards. Business Associate will develop, implement, maintain and use appropriate safeguards to comply with the HIPAA Rules and prevent use or disclosure of PHI (including electronic PHI) other than as provided in this Agreement or as required by law.

10. Subcontractors and Agents. Business Associate will ensure that any of its subcontractors and agents (to whom Business Associate provides PHI in connection with the Administrative Services) agrees to the same restrictions and conditions that apply to Business Associate hereunder, through a written agreement in accordance with §164.502(e)(1)(ii) and §164.308(b)(2), if applicable, of the HIPAA Rules.

11. Compliance with Standard Transactions. If Business Associate conducts, in whole or in part, Standard Transactions for or on behalf of Plan, Business Associate will comply and will require any of its subcontractors or agents involved with the conduct of such Standard Transactions to comply with each applicable requirement of 45 CFR Part 162. Business Associate will not enter into or permit its subcontractors or agents to enter into any trading partner agreement in connection with the conduct of Standard Transactions for, or on behalf of, Plan that: (a) changes the definition, data condition, or use of a data element or segment in a Standard Transaction; (b) adds any data elements or segments to the maximum defined data set; (c) uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or (d) changes the meaning or intent of the Standard Transaction's implementation specification.

12. Plan Access to PHI. Upon receipt of a request from Plan, and in accordance with the written policies of Business Associate then in effect, Business Associate will promptly make available to Plan or, at Plan's direction, to the individual requesting PHI (or the individual's personal representative) for inspection and obtaining copies of any PHI (including electronic copies of PHI in a designated record set as necessary) about said individual that is in Business Associate's custody or control, so that Plan may meet its access obligations under §164.524 of the HIPAA Rules.

13. Amendment of PHI. Business Associate will, upon receipt of notice from Plan, and in accordance with the written policies of Business Associate then in effect, promptly amend or permit Plan access to amend any portion of PHI, so that Plan may meet its amendment obligations under §164.526 of the HIPAA Rules. If authorized by Plan, Business Associate will, upon receipt of a request from the individual requesting amendment to his PHI, promptly amend such PHI so that Plan may meet its amendment obligations under §164.526 of the HIPAA Rules.

14. Disclosure Accounting. Except for Excepted Disclosures, Business Associate will record the Disclosure Information for each disclosure of PHI that Business Associate makes to any Person. Business Associate need not record Disclosure Information or otherwise account for Excepted Disclosures. Upon receipt of a request from Plan and in accordance with the written policies of Business Associate then in effect, Business Associate will make available to Plan, or at Plan's direction, to the individual requesting the disclosure accounting, the Disclosure Information for the six (6) years preceding Plan's request for the Disclosure Information (except for disclosures occurring before the Effective Date), so that Plan may meet its disclosure accounting obligations under §164.528 of the HIPAA Rules.

15. Inspection of Books and Records. Business Associate will make its internal practices, books, and records relating to its use and disclosure of PHI under this Agreement available to the U.S. Department of Health and Human Services for the purposes of determining Plan's compliance with the HIPAA Rules.

16. Reports to Plan. Business Associate will report to Plan promptly any use or disclosure of PHI that violates this Agreement of which Business Associate becomes aware, including breaches of unsecured PHI as required by §164.410 of the HIPAA Rules, and any Security Incident of which it becomes aware. Business Associate will further provide to Plan, in writing, such details concerning the incident in question as Plan may reasonably request.

In addition, Business Associate will report, without unreasonable delay but in no case later than 60 days following discovery of the breach, to the Plan's Privacy Official, any breach of unsecured protected health information. Such report shall include the identification (if known) of each person whose unsecured protected health information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such breach, along with any other information required to be reported by Business Associate to Plan under the HIPAA Rules. Unless notified otherwise by Plan, Business Associate will, on behalf of Plan, provide all notifications of breaches of unsecured protected health information as required in accordance with Subpart D of 45 C.F.R. Part 164, to the extent that the breached unsecured protected health information was in the possession of Business Associate or a subcontractor or agent of Business Associate. The terms "breach" and "unsecured protected health information" shall have the meanings ascribed to them in the HIPAA Rules.

17. Termination of Agreement for Cause. In the event of a breach of a material term of this Agreement by Business Associate, Plan shall have the right to terminate this Agreement by providing to Business Associate written notice of termination setting forth the details of the incident that is the basis for such termination. Business Associate shall have the right to cure any such breach within thirty (30) days from its receipt of said notice of termination (the "Cure Period"). A failure by Business Associate to cure such breach within the Cure Period shall constitute a breach of this Agreement entitling Plan to terminate this Agreement at any time after the Cure Period by providing to Business Associate written notice thereof specifying the effective date of termination. Plan,

Business Associate and Plan Sponsor hereby agree that, upon termination of this Agreement, the ASA shall terminate and Business Associate shall have no further obligation to perform the Administrative Services.

18. Obligations upon Termination.

A. **Return or Destruction.** Upon termination or expiration of this Agreement, Business Associate will, if feasible, return to Plan or destroy all PHI, in whatever form or medium (including any electronic medium under Business Associate's custody or control), including all copies of and any data or compilations derived from and allowing identification of any individual who is a subject of PHI. Business Associate will, in accordance with the written policies of Business Associate then in effect, complete such return or destruction as promptly as possible after the effective date of the termination or expiration of this Agreement. Business Associate will limit its further use or disclosure of PHI to those purposes that make return or destruction infeasible.

B. **Continuing Privacy and Other Obligations.** Business Associate's obligation to protect the privacy of PHI hereunder will be continuous and survive termination or expiration of this Agreement. The obligations of the parties hereto under Sections 12, 13, 14, 18 and 19 of this Agreement shall survive the termination or expiration of this Agreement.

19. Indemnification.

A. **Indemnification by Plan.** Plan hereby agrees to indemnify, defend and hold harmless Business Associate (including, without limitation, its officers, directors, employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to (i) the reliance of Business Associate upon Plan's representations, warranties, agreements or directions to Business Associate pursuant to this Agreement, or (ii) a breach of any of the terms and provisions of this Agreement by Plan or any party acting by or through Plan (including, without limitation, Plan's agents, employees, representatives, contractors or subcontractors).

B. **Indemnification by Plan Sponsor.** Plan Sponsor hereby agrees to indemnify, defend and hold harmless Business Associate (including, without limitation, its officers, directors, employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to (i) the reliance of Business Associate upon Plan Sponsor's representations, warranties, agreements or directions to Business Associate pursuant to this Agreement, or (ii) a breach of any of the terms and provisions of this Agreement by Plan Sponsor or any party acting by or through Plan Sponsor (including, without limitation, Designated Plan Sponsor employees, Plan Sponsor's agents, other employees, representatives, contractors or subcontractors).

C. **Indemnification by Business Associate.** Business Associate hereby agrees to indemnify, defend and hold harmless Plan (including, without limitation, its employees, agents, successors and assigns) from and against any and all claims, causes of action, liabilities, damages, costs, or expenses (including without limitation, attorneys' fees, court costs, costs of administrative or other proceedings, and costs of investigation) arising out of or related to a breach of any of the terms and provisions of this Agreement by Business Associate or any party acting by or through Business Associate (including, without limitation, Business Associate's agents, employees, representatives, contractors or subcontractors).

20. **Modification and Amendment.** Except as expressly modified or amended herein, all other terms and conditions of the ASA shall remain in full force and effect. This Agreement shall not be modified or amended in any respect except by a written instrument executed by the parties; provided, that in the event the provisions of this Agreement shall conflict with the requirements of applicable law concerning the use, handling, disclosure and/or treatment of PHI (including, without limitation, the HIPAA Rules), as such laws may be modified, amended, or superceded from time to time, this Agreement shall be deemed amended as necessary to conform to such legal requirements at all times.

21. **No Third Party Beneficiaries.** This Agreement is entered into by and among Plan, Plan Sponsor and Business Associate for the exclusive benefit of each of the parties hereto. This Agreement shall not be construed to confer any rights or remedies upon any Person, except the parties hereto and their respective officers, directors, shareholders, employees, agents, successors and assigns.

22. **Conflicts.** The terms and conditions of this Agreement will override and control any conflicting terms and conditions in the ASA related to the privacy and security of PHI.

[Signatures on next page]

IN WITNESS WHEREOF, the parties hereto have caused their duly authorized representatives to execute this Agreement, effective as of the Effective Date, in multiple originals on the date written below.

Plan:

City of San Luis Employee Benefit Trust Group Health Plan(s)

By: _____

Signature

Please print name

Date:

Plan Sponsor:

City of San Luis Employee Benefit Trust

By: _____

Signature

Please print name

Date:

Business Associate:

90 Degree Benefits, Inc.

By: _____

Signature

Bruce Flunker

Title: President

Date:

SCHEDULE A TO BUSINESS ASSOCIATE AGREEMENT

For purposes of this Agreement, all capitalized terms contained in this Agreement shall have the following meanings:

“Administrative Services” shall mean the administrative services that Business Associate provides to or on behalf of Plan in connection with administering the benefits provided by Plan as claims administrator of Plan under the ASA.

“ASA” shall mean one or more administrative services agreements (including any implementation or Enrollment Agreement between Business Associate and Plan Sponsor) which may be entered into by and between Business Associate and Plan Sponsor, from time to time, pursuant to which Business Associate provides the Administrative Services, as the same may be modified, amended, renewed or superceded.

“Business Associate” shall mean 90 Degree Benefits, Inc.

“Data Aggregation” shall have the meaning set forth in §164.501 of the HIPAA Rules.

“Designated Plan Sponsor Employees” shall mean those persons designated in writing by Plan to Business Associate, on or before the Effective Date, as being included within the class of employees or other workforce members under the control of Plan Sponsor designated in the Privacy Plan Amendment that are authorized to use and disclose PHI in accordance with the Privacy Plan Amendment.

“Disclosure Information” shall mean the information described in §§164.528(b)(2)-(3) of the HIPAA Rules.

“Effective Date” shall mean the effective date of the ASA.

“Excepted Disclosures” shall mean disclosures of PHI by Business Associate set forth in §164.528(a)(1) of the HIPAA Rules.

“Health Care Operations” shall have the meaning set forth in §164.501 of the HIPAA Rules.

“HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

“Payment” shall have the meaning set forth in §164.501 of the HIPAA Rules.

“Person” shall include individuals, trusts, estates, corporations (both non-profit and other corporations), partnerships (both limited and general), joint ventures, limited liability companies, unincorporated associations, and governmental agencies and organizations. Person shall not include Plan, Plan Sponsor or Business Associate.

“PHI” shall mean Protected Health Information that Business Associate receives from, or

creates or receives for, or on behalf of Plan in connection with the performance of the Administrative Services.

“Plan” shall mean one or more group health plans sponsored by Plan Sponsor to which Business Associate provides the Administrative Services.

“Plan Administrative Services” shall mean the plan administrative services performed by Plan Sponsor pursuant to the plan documents of Plan, including the Privacy Plan Amendment.

“Plan Sponsor” shall mean the entity who sponsors the Plan and who has executed this Agreement (by its duly authorized representative) on the signature line designated for the Plan Sponsor on the execution page of this Agreement.

“Privacy Plan Amendment” shall mean that amendment to the plan documents of Plan that complies in all respects with the requirements set forth in §164.504(f)(2) of the HIPAA Rules and for which Plan has received a written certification as required by the HIPAA Rules, on or before the Effective Date.

“Protected Health Information” shall have the meaning set forth in §160.103 of the HIPAA Rules.

“Security Incident” shall have the meaning set forth in §164.304 of the HIPAA Rules. However, unless otherwise requested by Plan, Security Incident does not include “trivial incidents” that occur on a daily basis and do not represent a material threat to the confidentiality, integrity, or availability of PHI covered by this Agreement (such as scans or pings of Business Associate’s computers or computer networks).

“Summary Health Information” shall have the meaning set forth in §164.504(a) of the HIPAA Rules.

“Treatment” shall have the meaning set forth in §164.501 of the HIPAA Rules.

APPENDIX D – SERVICE EXHIBITS

The Administrative Services Agreement, Appendixes and Exhibits set forth below, effective as of July 1, 2021, (the “Effective Date”), are attached hereto, incorporated herein, and collectively referred to as the “Agreement.”

The Agreement set forth in the Administrative Services Agreement, the terms and general provisions guiding the delivery of services by the Claims Administrator to the Plan Sponsor, in Articles I – X.

In addition to Articles I through X of the Administrative Services Agreement, the following Exhibits for specific services are selected by the parties to the Agreement to be part of the Agreement, and are outlined below.

Fees applicable to the Agreement are set forth in Appendix A – Fees and Services, which is attached hereto and incorporated herein. The following Exhibits *may* apply:

Exhibit I	Eligibility, Enrollment, Data Exchange and Billing
Exhibit II	Customized Web Portal
Exhibit III	PPO Access and Administration
Exhibit IV	Utilization Review
Exhibit V	Reporting
Exhibit VI	Cost Reduction and Savings Programs
Exhibit VII	Subrogation
Exhibit VIII	Pharmacy Benefit Management
Exhibit IX	Stop-Loss Negotiation & Administration
Exhibit X	90 Degree Benefits Healthier You/Disease
Mgmt. Exhibit XI	Consumer Benefit Account
Administration Exhibit XII	COBRA/HIPAA
Administration	
Exhibit XIII	Run-In Administration
Exhibit XIV	Run-Out Administration
Exhibit XV	Plan Document/Summary Plan Description
Exhibit XVI	Post-Termination Provider-Audit
Exhibit XVII	ACA Reporting

These Exhibits and fee schedules applicable to selected services set forth herein are effective as of the Effective Date.

EXHIBIT I – ELIGIBILITY, ENROLLMENT, DATA EXCHANGE AND BILLING

- 1.1 Claims Administrator will provide demographic information (as described in Article III) and if applicable, current benefit elections, based upon timely receipt of such information from the Plan Sponsor. Participant and benefit information, whether electronic or hard copy, must be in a format that is reasonably acceptable to the Claims Administrator.
- 1.2 An Optional Online Enrollment tool will be available to Plan Sponsor's authorized representatives, or to all Plan Participants, during Open Enrollment periods and throughout the Plan Year, subject to Plan Sponsor's direction.

Online Enrollment services may be provided for the following coverages:

- ☐ Medical Plan(s)
 - ☐ Consumer Benefit Accounts (FSA and HSA)
 - ☐ Dental
 - ☐ Vision
 - ☐ Short Term Disability
 - ☐ Long Term Disability
 - ☐ Plan Sponsor Paid Life
 - ☐ Supplemental Life
 - ☐ Other Plan Sponsor Paid Benefits
 - ☐ Other Voluntary Benefits
 - ☐ Other
- 1.3 Maintain Eligibility Records. Claims Administrator shall maintain Plan records based upon eligibility information submitted by the Plan Sponsor in an electronic or printed format and any changes in the manner described in Article III. Claims Administrator also shall maintain Plan records based on eligibility information submitted by the Plan Sponsor as to the dates on which a Plan Participant's coverage commences and terminates.
 - 1.4 Plan records shall be maintained in accordance with generally accepted standards of insurance bookkeeping. The Commissioner of the Department of Insurance shall be entitled to inspect all books and records of the Claims Administrator for the purpose of examinations and audits.
 - 1.5 If Claims Administrator is to maintain eligibility with respect to Retirees, all authority to convey, extend, except or terminate eligibility for retiree benefits is expressly reserved by the Plan Sponsor.
 - 1.6 Premium Only Plan Administration. Claims Administrator shall monitor enrollments and plan elections that confirm Plan Sponsors Plan Participants may pay for employee paid group insurance premiums to be paid with pre-tax dollars.

- 1.7 Eligibility Based upon Birthdate. Claims Administrator shall monitor birth dates of all retirees and dependents and shall alert Plan Sponsor, and all related agents and vendors, 90 days in advance of coverage changes mandated by age.
- 1.8 Data File Exchange. Claims Administrator will exchange standard file formats and data files with third parties. Such exchanges may occur during Open Enrollment, or on a periodic or recurring basis throughout the Plan Year.
- 1.9 Consolidated Billing. Claims Administrator will present all benefit bills to Plan Sponsor in a single monthly statement, accompanied by a detailed list bill. Upon remittance by Plan Sponsor, Claims Administrator will be responsible for payments to carriers and other vendors, and will resolve credits, corrections, additions, terminations, and notifications with each carrier and vendor partner. Claims Administrator also will be responsible for exchanging file formats and updating carrier and other vendors' eligibility.
- 1.10 Consolidated Billing will be provided for the following benefits, as directed by the Plan Sponsor:
- ☐ Medical Plan(s)
 - ☐ Consumer Benefit Accounts (FSA and HSA)
 - ☐ Dental
 - ☐ Vision
 - ☐ Short Term Disability
 - ☐ Long Term Disability
 - ☐ Plan Sponsor Paid Life
 - ☐ Supplemental Life
 - ☐ Other Plan Sponsor Paid Benefits
 - ☐ Other Voluntary Benefits
 - ☐ Other
- 1.11 Optional Retiree Billing. Claims Administrator shall make payments or issue bills and process manual payments for all retiree benefits [(monthly/bi-weekly/quarterly)]. Claims Administrator shall post payments, issue late notices, lapse notices, and termination notices where applicable. Claims Administrator shall remit funding received to Plan Sponsor, carriers, and other vendor partners on a [] basis, as appropriate or as agreed to by and between the parties.

EXHIBIT II – CUSTOMIZED WEB PORTAL

- 2.1 The Customized Web Portal enables Plan Sponsor to access data, and provides eligibility and claim information and reports.
- 2.2 Plan Sponsor will be provided with training on Web Portal functions, what its capabilities are, how it is utilized, and who they may contact for use support.
- 2.3 Plan Sponsor will have access to web-based tools, allow plan members to check status of claims, request identification cards, review balances (where applicable), access comprehensive plan information.
- 2.4 Various levels of access and information will be developed, with authorization to access different levels set by the Plan Sponsor. Plan Sponsor will be responsible for submitting customization requests, and provide a list of who is to be provided which level of access.

EXHIBIT III – PPO ACCESS AND ADMINISTRATION

- 3.1 Preferred Provider Organizations (PPO). Coordinate Preferred Provider Organization (PPO) services for the Plan Sponsor. A separate fee may be charged for this service. (Optional for DIYBS groups). The separate fee for PPO services will be payable by the Plan Sponsor. The Claims Administrator will submit payment on behalf of the Plan Sponsor to the vendor.
- 3.2 Service Area Access. Claims Administrator will provide Plan Sponsor with access to the network for Covered Services rendered in the Service Area (“Service Area Access”). Each Benefit Plan that selects the network for the Service Area shall utilize the network as its primary network.
- 3.3 Repricing Services. If applicable, the Claims Administrator will provide Plan Sponsor with repricing services as set forth under separate cover and incorporated herein.
- 3.4 Optional Out of Area Access. Claims Administrator will provide Plan Sponsor with access to the network for Covered Services rendered outside the Covered Person’s primary network service area.
- 3.5 Financial Responsibility of Payment to Providers. Plan Sponsor shall fund claims payable for the provision of medical services on behalf of Covered Individuals that portion of the contracted rate that exceeds the Copayment, Coinsurance and Deductible amounts specified in the applicable benefit Plan and which is not otherwise excluded or limited by such Benefit Plan.
- 3.6 Plan Sponsor shall be deemed to be the payer for network agreement purposes, and will be responsible for abiding by the terms of the applicable network agreement(s). Payment and costs incurred by virtue of provider services.
- 3.7 If Plan Sponsor chooses not to access a Network Agreement at any time, and compensates a provider utilizing a non-network rate, the Plan Sponsor shall be solely responsible for fees and costs arising from that decision. Claims Administrator will never be called upon to advance its own funds towards the payment of any provider.
- 3.8 Out of Network Program. Claims Administrator may make an Out of Network Program available if elected by Plan Sponsor. The program provides access to discounted charges from health care providers which are made available to Claims Administrator for use with the employee benefit plans that Claims Administrator administers.

- (a) **Benefits Payable.** The benefits payable shall be determined based on the discounted charges under the Out of Network Program. If a health care provider participates in a “managed care network” provided to Plan Sponsor by Claims Administrator, the benefits payable for services rendered by those providers shall be based on the rates set forth in the agreement with the “managed care network” and not based on the discounts available under the Out of Network Program.
- (b) **Provider Directories.** Provider directories or other listings of the health care providers under this program shall not be provided to the Plan Sponsor.
- (c) **Services.** The services provided under this program are quantitative only and Claims Administrator’s services under this program do not include credentialing of health care providers or any other quality management activities.
- (d) **Termination.** Claims Administrator may terminate the Out of Network Program in whole or in part at any time for any reason upon written notice to Plan Sponsor. Plan Sponsor may terminate the program at any time for any reason upon giving Claims Administrator written notice. Claims Administrator shall implement such termination within a reasonable period of time after receiving such notice.

EXHIBIT IV – UTILIZATION REVIEW

4.1 Claims Administrator shall provide utilization review services through 90 Degree Benefits Inc. Review (formerly EBSO Review). Services *may* include

(i) provision of the notification process for inpatient admissions
optional outpatient surgeries

optional outpatient psychiatric day treatment and/or chemical dependency and
other treatments or procedures provided for under the terms of the Plan
Documents,

(ii) pre-admission review, outpatient surgical review, outpatient psychiatric day
treatment and/or chemical dependency center review and discharge
planning,

(iii) medical and large case management for catastrophic illness or injury,

(iv) comprehensive physician review of clinical records for denials or appealed
notifications as necessary;

(v) and pharmaceutical physician peer review as necessary.

EXHIBIT V – REPORTING

Claims Administrator will provide to Plan Sponsor the following reports as outlined below:

- 5.1 Weekly or as agreed to by and between the parties claims funding invoices evidencing claims submitted by providers for payment; monthly or as agreed to by and between the parties check registers evidencing payment made by plan to providers; monthly or as agreed to by and between the parties cumulative aggregate deductible to paid claims report; monthly or as agreed to by and between the parties summary of benefits paid report by type of claim, provider and total dollar amounts; annual report within 30 days after close of the Plan Year, and any other reports requested by Plan Sponsor which Claims Administrator agrees to produce and which both parties agree to in writing.
- 5.2 The reports outlined above will be delivered to Plan Sponsor's designated representative.
- 5.3 Weekly reports will be delivered via secure email. Monthly reports will be delivered by secure email and posted to the web portal.
- 5.4 Reports (*not all reports are available to every group*):
 - ☐ Weekly
 - Zero Balance Fund Request Reports (only if non-level funded client)
 - ☐ Monthly
 - Fund Account Report (for level funded groups)
 - Monthly Total Paid Claim Report
 - Monthly Check Register
 - Monthly Total Plan Cost Report
 - Monthly Individual Specific Analysis Report
 - Monthly MBI Debit Card Balance Report
 - Monthly Census Report
 - Monthly Admin Fee Report
 - ☐ Quarterly
 - Quarterly FSA Statement
- 5.5 Reports will be produced in a PDF format or Excel if requested.
- 5.6 Reports will be delivered as agreed by and between the parties.
- 5.7 Plan Sponsor will provide a list of contact(s) to whom reports will be delivered, when reports are to be delivered, and to whom which report(s) should be sent.
- 5.8 Claims Administrator will provide a contact(s) which may be contacted for a report, which will be produced and provided within a reasonable timeframe.

EXHIBIT VI – COST REDUCTION AND SAVINGS PROGRAMS

- 6.1 Coordinate inpatient and outpatient hospital and professional fee negotiation services for the Plan Sponsor. A separate fee will be charged for this service. The separate fee for fee negotiation services will be payable by the Plan Sponsor to the Claims Administrator.
- 6.2 Claims Administrator will review with the Plan all cost containment options and will, in writing, agree upon which services Plan Sponsor desires to utilize;
- 6.3 Claims Administrator will, when it becomes aware of additional cost containment services, advise the Plan of these opportunities and the associated costs involved in writing;
- 6.4 If Plan elects to utilize any of the services outlined herein, Claims Administrator shall not be liable for the terms of use;
- 6.5 Cost Reduction and Savings Program. Coordinate inpatient and outpatient hospital and professional fee negotiation services for the Plan Sponsor. A separate fee will be charged for this service. The separate fee for fee negotiation services will be payable by the Plan Sponsor.

EXHIBIT VII – SUBROGATION

- 7.1 The Plan Sponsor and Claims Administrator hereby agree that Claims Administrator will perform certain services in connection with the Plan regarding subrogation and reimbursement rights of the Plan for the fees stated herein.
- 7.2 The Phia Group shall provide recovery services for subrogation/reimbursement of Claims paid by the Plan.
- 7.3 Subrogation services shall include direct recovery on behalf of the Plan against third parties and reimbursement services shall include recovery of Plan funds from those Covered Persons who have recovered damages from third parties; (including identification of potential subrogation and reimbursement claims, follow up questionnaires to Covered Persons and Health Care Providers, provision of a copy of subrogation forms signed by the Employee to the Plan Sponsor, provision of updated reviews of subrogation efforts, additional research as necessary, notification to Health Care Providers, Covered Persons, and their authorized representatives, settlement of claims with prior authorization from the Plan Sponsor, and other acts necessary to effectuate recovery of Plan funds).
- 7.4 If necessary to retain outside legal counsel for recovery of Plan funds, the Plan Sponsor shall have sole discretion to select and retain legal counsel.
- 7.5 Plan Sponsor and Claims Administrator acknowledge that negotiation or waiver of a subrogation/reimbursement claim may be necessary as a result of state or federal law or the specific facts and circumstances of the disputed Claim. The Claims Administrator shall refer any requests for negotiation or waiver of a claim to the Plan Sponsor for final settlement.

EXHIBIT VIII – PHARMACY BENEFIT MANAGEMENT

- 8.1 Pharmacy Benefit Management. Claims Administrator will trade eligibility with the pharmacy vendor partner. Claims Administrator will analyze pharmacy expenditures and offer care management and cost containment ideas for the benefit of Plan Sponsor and Plan Participants. It will further coordinate Prescription Benefit Management (PBM) services as needed.
- 8.2 (Optional) Identification Cards. Claims Administrator will provide one I. D. Card per Employee and an additional card for family coverage upon enrollment as part of its Pharmacy Benefit Management services. An additional fee may apply if the Claims Administrator is required to mail the cards to individual employees' homes or an alternative address. Replacement cards will be issued as necessitated by coverage changes or Employee needs.

EXHIBIT IX – STOP-LOSS NEGOTIATION & ADMINISTRATION

- 9.1 Procure excess loss or stop loss (specific and aggregate) insurance proposals and policies for the Plan Sponsors consideration and selection, which excess loss or stop loss insurance will be an asset of the Plan Sponsor and not of the Plan (if applicable). In the event that the Claims Administrator does not procure excess loss or stop loss insurance for Plan Sponsor or assist Plan Sponsor in such procurement, Plan Sponsor shall indemnify, defend, and hold harmless Claims Administrator and its respective officers, partners, employees and agents from and against any and all expenses, claims, settlement costs, penalty, damages, judgements, attorney's fees, actions or causes of action whatsoever to the extent that such expenses, damages, and/or claims, etc., result from a claim and/or action brought by, or on behalf of, the excess loss or stop loss carrier, excess loss coverage or stop loss coverage, or are related to the lack of coverage thereof, and/or in any way connected with any act, failure to act, the performance of and/or failure to perform any and all obligations by or related to the excess loss or stop loss coverage selected and procured by the Plan Sponsor or its Broker/Agent. This provision shall survive the termination of any applicable excess loss or stop loss policy and/or contract as well as this Agreement.
- 9.2 Notify the excess loss insurance company of any potential large Claims which may become a Claim under the excess loss coverage. On behalf of the Plan, the Claims Administrator will file in a timely manner any Claims for benefits under the excess loss policies.
- 9.3 Promptly pay on behalf of the Plan Sponsor any premium and other notices received from the excess loss insurance company concerning the policy.
- 9.4 Responsibilities of Claims Administrator. To the extent specified below, Claims Administrator shall provide the services for, and shall assist the Plan Sponsor in the analysis of their stop-loss coverage, if any, as follows:
 - (a) Annually market the excess loss coverage to a select number of insurance and reinsurance carriers in order to obtain alternate quotes for comparison.
 - (b) Prepare and deliver renewal proposal prior to renewal date.
 - (c) Provide supporting claims documentation to support renewal action.
 - (d) Interpret and analyze claim information in order to make suggestions for possible plan design changes.
 - (e) Upon renewal, complete all applications, forms and amendments for Plan Sponsor signature.
 - (f) Communicate renewal decisions to Claims Administrator departments and all appropriate carrier(s) and/or vendor(s).

**EXHIBIT X – 90 Degree Benefits Healthier You/Disease
Management**

- 10.1 Health Risk Assessment. Claims Administrator shall provide to all adult Plan Participants a series of health-related questions online. Plan Participants will receive a personal report and recommendations via email. Claims Administrator will prepare for Plan Sponsor a report aggregating data from individual assessments. No personal information will be conveyed in the report to Plan Sponsor. Recommendations to improve Plan Sponsors overall health and reduce benefit costs will be offered by Claims Administrator. Claims Administrator will, at the Plan Sponsors request, recommend and coordinate incentive awards related to the Health Risk Assessment.
- 10.2 Health Management Program. Registered Nurses of Claims Administrator will review Health Risk Assessments, and analyze claims and prescription history, if available, to identify at-risk Plan Participants. Through written, personal communications, at-risk Plan Participants will be invited to participate in a one-on-one Health Management Program with a Registered Nurse/Certified Case Manager. The program will be customized for individual Plan Participant risk factors. Recommendations and resources will be offered in order to manage or improve chronic health risks. Claims Administrator will, at Plan Sponsors request, recommend and coordinate incentive awards related to participation in the Health Management Program.

EXHIBIT XI – CONSUMER BENEFIT ACCOUNT ADMINISTRATION

11.1 Claims Administrator Responsibilities (in addition to Article III).

- (a) Examine each claim for benefits under the Cafeteria Plan, take reasonable steps to verify its validity, compute the amount payable (if any) and either disburse the benefit due under the Cafeteria Plan, or deny the claim.
- (b) Administer consumer benefit accounts subject to the provisions and conditions set forth below:
 - (1) The Plan Sponsor will deposit funds into a designated bank account to be used in the disbursement of benefit payments to participants. Payment of claims by Claims Administrator is hereby authorized and will be made from the Plan Sponsor's bank account.
 - (2) Claims Administrator will rely on one or more of the following in processing claims made under the Cafeteria Plan: IRS Code, Sections 105, 106, and 125; the Cafeteria Plan Document; the Summary Plan Description; the Administrative Agreement; standard practices of the life and health insurance industry; and any other laws, regulations or ruling(s) relating to Cafeteria Plan matters.

11.2 Plan Sponsors Responsibilities (in addition to Article IV).

- (a) Serve as the Cafeteria Plan Sponsor as those terms are defined in ERISA. As such, the Plan Sponsor is responsible for the general management and administration of the Cafeteria Plan, including but not limited to, the following:
 - (1) Executing an agreement establishing the Trust for contributions of the Plan Sponsor and/or participants on or before the effective date of the Cafeteria Plan;
 - (2) Establishment, amendment and termination of the Cafeteria Plan and establishment of a funding policy for the Cafeteria Plan;
 - (3) So long as the Plan Sponsor is so notified, indemnify and hold Claims Administrator, its officers, agents, or employees harmless from any and all loss, damages, claims, suits, interest, costs and expenses (including Attorneys' fees), that Claims Administrator may sustain or become liable

for or pay upon or in consequence of any liability to payees, endorser, endorsees, holders or the drawee bank or any collecting bank or banks arising out of the failure of the drawee bank to honor any draft described in the preceding paragraph by reason of inadequacy of funds in said escrow account or for any other reason whatsoever, provided, however, that such loss, damages, claims, suits, interest, costs and expenses

- (4) Final interpretation of the Cafeteria Plan, including determination of eligibility and amount, manner and time of Cafeteria Plan benefit payments;
- (5) Enrollment of eligible persons in the Cafeteria Plan and provision to Claims Administrator of a complete and accurate Enrollment Form (electronic or hard copy) for each participant prior to the effective date of this Agreement;
- (6) Obtaining written waivers of Cafeteria Plan coverage from eligible persons declining such coverage;
- (7) Forwarding to Claims Administrator electronic or written notice of all persons beginning coverage under the Cafeteria Plan and persons terminating coverage and complete accurate enrollment information for new participants;
- (8) Reviewing Claims Administrator's monthly billing statement for accuracy of enrollment records and immediately informing Claims Administrator of inaccuracies.

11.3 General Provisions.

- (a) The legal and tax status of the Cafeteria Plan under applicable law, including compliance with Sections 105, 106, 125 of the Code is a matter for determination by the Plan Sponsor and not by Claims Administrator, which is not responsible therefore. Claims Administrator is neither the Cafeteria Plan Administrator nor a named Fiduciary of the Plan as these terms are defined in ERISA.
- (b) If ERISA requires that the Cafeteria Plan be audited annually by an independent, qualified public accountant, the Plan Sponsor is responsible for arranging for and paying the cost of the audit.
- (c) If the Plan Sponsor or the Cafeteria Plan is investigated or audited by any state or federal governmental agency, Claims Administrator will fully cooperate with such agency's reasonable and lawful request for information. Any and all costs to Claims Administrator of such investigation or audit will be borne by the Plan Sponsor.

EXHIBIT XII – COBRA

12.1 Claims Administrator's Responsibilities (in addition to Article III). To the extent specified below, Claims Administrator shall provide the services for, and shall assist the Plan Sponsor in the administration of COBRA Continuation Coverage and HIPAA, as follows:

- (a) To mail to Qualified Beneficiaries at the time Claims Administrator is notified of a Qualifying Event, an election form for COBRA Continuation Coverage.
- (b) To provide Qualified Beneficiaries, who elect COBRA Continuation Coverage, appropriate claims, supplies and instruction for the filing of claims.
- (c) To provide Qualified Beneficiaries with coupons for the purpose of remitting monthly payments to the COBRA Sponsor.
- (d) Obtain and forward to the COBRA Plan Sponsor all monthly remittances.
- (e) To notify Qualified Beneficiaries that their coverage is in a state of lapse or has terminated due to failure to pay premium.
- (f) Claims Administrator is authorized to do all acts it deems necessary or convenient to carry out the terms and purposes of this Agreement.

12.2 Plan Sponsor/COBRA Sponsors Responsibilities (in addition to Article IV). The parties hereto agree that the effective performance of all obligations hereunder by Claims Administrator will require that the COBRA Plan Sponsor furnish to Claims Administrator certain timely reports and information which Claims Administrator Sponsor agrees to so provide as follows:

- (a) COBRA Plan Sponsor shall provide written notice to Claims Administrator of the occurrence of a Qualifying Event with respect to any Covered Person, including:
 - (1) The name of the Covered Person;
 - (2) The unique identifier of the Covered Person;
 - (3) The date of birth of the Covered Person;
 - (4) The date of the Qualifying Event; and

- (5) The date a qualified beneficiary has been determined (under Title 11 or XVI of the Social Security Act) to be disabled at the time of the qualifying event or is no longer disabled; and
- (6) The current address of the Covered Person in order for Claims Administrator to mail COBRA Continuation Coverage information. (Subsequent notification of address changes is the responsibility of the Qualified Beneficiary). Such notice shall be delivered to both the Plan Administrator and Claims Administrator within the time required by COBRA.
- (7) COBRA Plan Sponsor shall also provide such additional information or documentation which, in the opinion of Claims Administrator is necessary in order for Claims Administrator to perform its services under this Agreement. Claims Administrator shall not be responsible for delay in the performance of its services caused by the failure of the COBRA Sponsor to promptly furnish any and all required information.
- (8) The COBRA Plan sponsor shall notify Claims Administrator of any inquiries by Covered Persons pertaining to the COBRA Continuation Coverage. The COBRA Plan Sponsor shall comply with COBRA and all other applicable Federal, State and local laws and regulations in connection with the COBRA Continuation Coverage.

12.3 Indemnification. Claims Administrator, in performing its obligations under this Agreement, is acting only as an independent contractor for the COBRA Sponsor. For the purposes of ERISA, COBRA and any applicable state legislation of a similar nature, the COBRA Sponsor shall be deemed to be the administrator of the Plan.

In no instance shall Claims Administrator be deemed to be, or be, the administrator of the Plan for purposes of ERISA, or the Plan Sponsor under Section 4980 13(g) (3) of the Internal Revenue Code of 1986, as amended from time to time. Claims Administrator has no discretionary authority or control with respect to the Plan or the COBRA Continuation Coverage and is not a fiduciary of the Plan, it being understood that Claims Administrator's services hereunder are purely administrative functions within the framework of policies, interpretations, rules, practices and procedures set down by the COBRA Sponsor.

It is understood that the legal and tax status of the Plan and the COBRA requirements under applicable law are matters for determination by the COBRA Sponsor and that Claims Administrator has given COBRA Sponsor no advice with respect to the legal and tax status of the Plan or compliance with COBRA and bears no responsibility therefore.

EXHIBIT XIII – RUN-IN ADMINISTRATION

- 13.1 Run-In Claims. Claims Administrator agrees to assume responsibility for administering claims incurred prior to the effective date, for the period (N/A) through (N/A) on a case-by-case basis, as requested by the Plan Sponsor.
- 13.2 Other Agreement Terms. All of the other terms of this Administrative Services Agreement will apply to these pre-effective date services.
- 13.3 Plan Sponsor to assist in obtaining detailed claim history reports for the run-in period including deductible and out of pocket maximum accumulator reports.

EXHIBIT XIV – RUN-OUT ADMINISTRATION

- 14.1 Run-Out Claims. Upon termination of the Administrative Services Agreement, Claims Administrator will have no obligation to process claims received ten (10) days prior to the Termination Date, or after the Termination Date. The Plan Sponsor may request the Claims Administrator, and the Claims Administrator may agree, to process claims incurred prior to the Termination Date. The time period during which the Claims Administrator will process such claims shall be agreed to by both parties, but shall be no less than ninety (90) days to a maximum of twelve (12) months.
- 14.2 Agreement Breach. Claims Administrator will not provide claim processing services after termination of the Agreement if the Agreement was terminated because Plan Sponsor failed to pay Claims Administrator fees due or Plan Sponsor did not provide required funding or, at Claims Administrator's option, when there is termination for any other reason under the Agreement.
- 14.3 Other Agreement Terms. All of the other terms of this Administrative Services Agreement will apply to these post-termination services as though the Agreement continued to be in effect.

EXHIBIT XV – PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION / SBC

- 15.1 Prepare a draft Plan Document and Summary Plan Description. Claims Administrator or its designee, will, at Plan's request, prepare and maintain a specimen Plan Document and Summary Plan Description in a format acceptable to the Plan and subject to final approval by Plan and/or Plan's legal counsel.
- 15.2 Prepare Plan Document amendments for review and final approval by Plan Sponsor.
- 15.3 Claims Administrator, or its designee, will furnish a master Summary Plan Description to the Plan Sponsor, either electronically or in printed form pursuant to Plan's direction.
- 15.4 Claim Administrator will prepare and furnish SBCs as required by applicable law.

EXHIBIT XVI – POST-TERMINATION PROVIDER-AUDIT

16.1 WHEREAS, Claims Administrator on behalf of Plan Sponsor entered or may enter into agreements with Healthcare Networks and/or Preferred Provider Organization Networks (the “Networks”), which enable Plan Sponsors’ plans and/or participants to receive contracted rates for medical services from Preferred Providers that are less than the Preferred Providers’ normal billed charges for such medical services;

16.2 WHEREAS, the Networks have entered into contracts with the Preferred Providers (generally, “Hospital Services Agreements”) that set forth the contract rates for the medical services provided for Plan participants that are less than the Preferred Providers’ normal billed charges;

16.3 WHEREAS, some or all of the Hospital Services Agreements may contain contractual provisions that require the Plan to pay the contract rate amount due on or before the [30th day (or 45th, as applicable)] after a clean claim is received by the Administrator (the “Prompt Payment Deadline”);

16.4 WHEREAS, some or all of the Hospital Services Agreements further provide that, if the contract rate amount is not paid on or before the Prompt Payment Deadline, then the Plan may owe the Preferred Provider the normal billed charges for such medical services, which in all cases is substantially greater than the contract rate; and

THEREFORE, with respect to such Preferred Providers, Plan Sponsor agrees as follows:

16.5 Plan Sponsor authorizes Claims Administrator to enter into agreements with Networks that adopt, assume or otherwise make Plan Sponsor a party to, or bound by, the terms of the Hospital Services Agreements, including, but not limited to, the Prompt Payment Deadline, if any.

16.6 Plan Sponsor understands that paying for medical services on or before the Prompt Payment Deadline may result in the Plan paying for medical services that are not “covered services” as that term is defined in the Plan, in order to avoid prompt payment penalties.

16.7 To the extent that the Plan fails or refuses to pay for Covered Services prior to the Prompt Payment Deadline and the Preferred Provider seeks the difference between the contract amount and normal billed charges, Plan Sponsor will indemnify and hold Claims Administrator harmless from any and all indirect, special, consequential, penalty or incidental damages in connection with or arising out of the Plan’s failure and/or refusal to pay for such Covered Services prior to the Prompt Payment Deadline, including, but not limited to, any and all liabilities, obligations, costs, claims, judgments, attorney fees, and attachments related to same.

16.8 To the extent that the Benefits Program pays for services that are not Covered Services in order to meet the Prompt Payment Deadline, it shall be Plan Sponsor’s sole responsibility to recoup the payment and/or obtain a refund of the payment from the Preferred Provider. Plan Sponsor expressly assumes the risk and acknowledges that, in order to meet the Prompt Payment Deadlines, if any, Plan Sponsor may pay for medical services that are not Covered Services and may be required to seek reimbursement of the amounts paid to the Preferred Providers. Plan Sponsor will indemnify and hold Claims Administrator harmless from any and all indirect, special, consequential, penalty or incidental damages in connection with or arising out of the

EXHIBIT XVI – POST-TERMINATION PROVIDER-AUDIT (continued)

Plan's payment for services that ultimately determined not to be Covered Services, including, but not limited to, any and all costs of collection, liabilities, obligations, costs, claims, judgments, attorney fees, and attachments related to same.

EXHIBIT XVII – ACA REPORTING

- 17.1 Claim Administrator will assist the Plan Sponsor with reporting requirements under Internal Revenue code Sections 6055 and 6056.
- 17.2 Claim Administrator will assist in the validation of information and preparation of Form 1095-C to be distributed to employees
- 17.3 For Applicable Large Employers, over 50 FTEs, Claim Administrator will prepare and file Form 1094-C and Form 1095-C with the IRS.
- 17.4 Claim Administrator will provide an electronic file to the Plan Sponsor for its records.
- 17.5 Claim Administrator will comply with all mandated deadlines for distribution and filing.



ECHO 90 DEGREE BENEFITS AUTHORIZATION AND GUARANTEE AGREEMENT

**FOR
AUTOMATED CLEARING HOUSE ("ACH") AUTHORITY**

EMPLOYER BENEFIT PLAN NAME: City of San Luis Employee Benefit Trust
(hereinafter called Employer Benefit Plan)

EMPLOYER BENEFIT PLAN NUMBER: SLS001 (By Its Third Party Administrator, hereinafter called TPA)

NAME OF TPA: 90 Degree Benefits, Inc.

Employer Benefit Plan hereby authorizes **ECHO Health, Inc.**, hereinafter called "**ECHO**", to initiate debit entries for approved benefit plan payments and to initiate, if necessary, credit entries and adjustments for any debit entries in error, refunds received for Employer Benefit Plan's account indicated below at the depository named below at the depository named below, hereinafter called "Depository".

DEPOSITORY NAME: _____

DEPOSITORY ADDRESS: _____

TRANSIT/ABA NO. _____ ACCOUNT NO. _____
(Bank Routing No. - first set of numbers from checking account) (Please include a copy of a deposit slip)

Employer Benefit Plan does hereby agree and guarantee that the funds required will be on deposit in the account specified above within twenty four (24) hours of its approval of benefit payments from its TPA, its claim administrator. Further, funds, once available, will be withdrawn from this account and will be deposited in an account established by ECHO at ECHO's clearing bank. Failure to fund such account in such timely manner may result in a delay of payments. Any fines or penalties assessed to the account established by ECHO will be the responsibility of Benefit Plan Employer. Continued failure to fund such account may result in a loss of service for the payment of claims.

ECHO will pay the costs related to the establishment, maintenance and activity of accounts at its clearing bank or banks. Any credits or interest earned by reason of the maintenance and use of such accounts shall be the property of ECHO and may be used by it, including, but not limited to the payment of all such costs.

This authority and guarantee is to remain in full force and effect until ECHO and Depository have received written notification from Benefit Plan Employer of its termination in such time and in such manner as to afford ECHO and Depository a reasonable opportunity to act on it.

EMPLOYER BENEFIT PLAN NAME: _____

EXECUTED BY: _____

TITLE: _____

DATE: _____

**City of San Luis
EMPLOYEE BENEFIT TRUST**

**SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT**

90 DEGREE BENEFITS GROUP NUMBER: SLS001

Effective: July 1, 2018

Revised and Restated July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, the Plan Sponsor establishes City of San Luis Employee Benefit Plan (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 card 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

90 Degree Benefits, 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.

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 in order to provide comprehensive healthcare benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust 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
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
Plan Number:	501
90 Degree Benefits 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

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust

Claims Administrator:

90 Degree Benefits, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: 90 Degree Benefits, 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

PPO: \$750 INDIVIDUAL
\$1,500 FAMILY

NON-PPO: \$1,500 INDIVIDUAL
\$3,000 FAMILY

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

PPO: \$4,500 INDIVIDUAL
\$9,000 FAMILY

NON-PPO: \$20,000 INDIVIDUAL
\$40,000 FAMILY

The PPO Annual Out-of-pocket Maximum and the Non-PPO 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 Deductible, 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)
- Complex Imaging services: CT/PET/MRI/MRA/SPECT
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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

PPO: \$500 per service or

Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

THE PPO IS ADMINISTERED BY: **BCBS of Arizona**
Multiplan wrap
In Mexico, SIARMED

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.

This plan may provide a higher reimbursement for services received through the Exclusive Surgeries Solutions LLC (ESurgeries) Surgical Management Program (surgery and complex imaging procedures.)

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Acupuncture	80% after Deductible	50% after Deductible	LIMITED to a maximum of 26 visits per Coverage Year.
Ambulance Services -Air and Ground	80% after Deductible	80% after Deductible	
Amino acid-based formula	25% after Deductible	25% after Deductible	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for amino acid based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Plan Member per Coverage Year.
Chiropractic Care	100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible	Includes x-rays, manipulations, supportive care, and maintenance care. LIMITED to a maximum of 20 visits per Coverage Year.
Dental Hospitalization and Dental Services Office Visits	80% after Deductible	50% after Deductible	Diagnostic procedures & treatment of TMJ are LIMITED to a Lifetime maximum benefit payment of \$300.
COVID-19 tests and vaccine administration	100% (Deductible waived)	100% (Deductible waived)	Includes testing, related services, and vaccine administration to the extent required by law.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	50% after Deductible	Hearing aids are LIMITED to one per Coverage Year.
Emergency Services and Urgent Care Services Emergency visit Urgent Care	80% (Deductible waived). 100% after a \$30 Copay per visit (Deductible waived)	80% (Deductible waived). 50% after Deductible	In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
ESurgeries Procedures	100% (Deductible waived)	Not applicable	
Home Health Care	80% after Deductible	50% after Deductible	LIMITED to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	50% after Deductible	Bereavement Counseling is LIMITED to a Lifetime maximum benefit payment of \$300 per family.
Inpatient Hospital Services (Non-Emergency), Outpatient Hospital, or Ambulatory Surgical Center Services ESurgeries providers All others	100% (Deductible waived). 80% after Deductible	Not Applicable 50% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Inpatient and Outpatient Physician Services			
Primary Care Physician Office Visits (includes lab and X-ray)	100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible	
Specialist Office Visits (includes lab and X-ray)	100% after a \$25 Copay per visit (Deductible waived)	50% after Deductible	
Inpatient Visit	100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (Physician's office)	100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (other) – ESurgeries	100% (Deductible waived).	Not Applicable	
Surgery (other)	80% after Deductible	50% after Deductible	
Physician Services – Pathology, Anesthesiology , or Radiology	80% after Deductible	50% after Deductible	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Medical Foods	50% after Deductible	Not covered except in an Emergency. In an Emergency, covered expenses will be paid at PPO level.	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Plan Member per Coverage Year.
Mental/Nervous Disorders and/or Substance Abuse			
Inpatient treatment	80% after Deductible	50% after Deductible	
Outpatient treatment	100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible	
Outpatient Diagnostic Tests			
Complex - MRI, MRA, CT, PET, SPECT			
Through ESurgeries provider	100% (Deductible waived).	Not Applicable	
Other providers:	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests			
Through ESurgeries provider	100% (Deductible waived).	Not Applicable	
Other providers	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests – Primary care office visit	100% (Deductible waived)	50% after Deductible	
Other X-rays and Laboratory tests – Specialist care office visit	100% (Deductible waived)	50% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Preventive Care Services Pediatric and Adult Preventive Care Immunizations, inoculations, vaccinations Sterilization – limited to Employee and covered Spouse only	100% (Deductible waived) 100% (Deductible waived) 100% (Deductible waived)	80% after Deductible 100% after a \$20 Copay per visit (Deductible waived) 80% after Deductible	Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives, unless covered under the Prescription Drug Card Benefit. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.
Rehabilitation and Habilitation Services Physical, Speech, Occupational Therapy All Other	100% after a \$30 Copay per visit (Deductible waived) 80% after Deductible	50% after Deductible 50% after Deductible	Physical, Occupational and Speech therapy are LIMITED to a maximum of 60 Outpatient visits per Coverage Year, combined.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	LIMITED to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	50% after Deductible	
Transplants Hospitalization Associated Office Visits	80% after Deductible 100% after a \$15 Copay per visit (Deductible waived)	50% after Deductible 50% after Deductible	
All other Covered Expenses	80% after Deductible	50% after Deductible	

PRESCRIPTION DRUG CARD EXPENSE BENEFIT

NOTE: Copays may not apply to certain preventive prescription and over-the-counter medications. Contact the Prescription Drug Card Administrator for more information. Note: the brand name copay will apply to a brand name contraceptive if a generic version is available and just as effective and safe.

Prescriptions must be obtained through Magellan Rx, except in an emergency. Prior authorization is required for some prescription drugs.

Retail (30 day supply)

Formulary Generic/Diabetes syringes or lancets	\$5 Copay
Formulary Brand	\$35 Copay
Non-Formulary Brand	\$55 Copay
Diabetic insulin (2 vials) or test strips	\$25 Copay

Magellan Rx Mail Service Program (90 day supply)

Formulary Generic/Diabetes syringes or lancets	\$15 Copay
Formulary Brand	\$75 Copay
Non-Formulary Brand	\$135 Copay
Diabetic insulin (6 vials) or test strips	\$75 Copay

THE PRESCRIPTION DRUG CARD EXPENSE BENEFIT IS ADMINISTERED BY: Magellan Rx

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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, Deductible 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. Copays do not count toward the Deductible.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services after any applicable Deductibles and 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.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

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.

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. Employee also includes Council Members who are working a minimum of 20 hours per month.

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, social worker, 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 AGENCY means a public agency or private organization which meets all of the following requirements:

1. Is primarily engaged in providing care to Terminally Ill patients;
2. Provides 24-hour care to control the symptoms associated with Terminal Illness;
3. Has on its staff an interdisciplinary team which includes at least one Physician, one registered professional nurse (R.N.), one social worker, and at least one pastoral or other counselor, and volunteers;
4. Must be a licensed organization whose standards of care meet those of the National Hospice Organization;
5. Maintains central clinical records on all patients;
6. Provides appropriate methods of dispensing drugs and medicines; and
7. Offers a coordinated program of home care and Inpatient care for a Terminally Ill patient.

The term "Hospice" does **NOT** include an organization or part thereof which:

1. Is primarily engaged in providing:
 - a. Custodial Care;
 - b. Care for Substance Abusers; or

- c. Domestic services;
- 2. Is a place of rest;
- 3. Is a place for the aged; or
- 4. Is a hotel or similar institution.

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.

INHERITED METABOLIC DISORDERS means an inherited disorder: (1) specified in the newborn screening program prescribed by Arizona law, Including phenylketonuria (PKU), maple sugar urine disease, homocystinuria, and galactosemia; (2) involving amino acid, carbohydrate, or fat metabolism; (3) having medically standard methods of diagnosis, treatment, and monitoring Including quantification of metabolites in blood, urine, or spinal fluid or enzyme or DNA confirmation in tissues; and (4) requiring specially processed or treated medical foods: (i) that are generally available only under the supervision and direction of a Physician, (ii) that must be consumed throughout life, and (iii) without which the Plan Member may suffer serious mental or physical impairment.

Any condition not included in the newborn screening program is not an Inherited Metabolic Disorder.

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 Center, Home Health Care Agency, Hospice, Hospital, Skilled Nursing 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.

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, chiropractic, 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.

PREFERRED PROVIDER ORGANIZATION (PPO) means a specific group of healthcare providers who have joined together in an arrangement to provide medical services on a more favorable basis in terms of price and utilization than is generally offered to the public on an individual practitioner basis.

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.

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.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) AND/OR MYOFASCIAL PAIN DYSFUNCTION (MPD) means jaw joint conditions including craniomandibular disorders; and all other conditions of the joint linking the jaw bone, skull; and the complex of muscles, nerves and other tissues related to that joint.

TERMINALLY ILL or TERMINAL ILLNESS means a Plan Member has an incurable diagnosis and medical prognosis of limited life expectancy, usually 6 months or less.

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
90 Degree Benefits, 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
90 Degree Benefits, 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
90 Degree Benefits, 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, except as specifically listed otherwise in the Plan.
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.
6. **Anonymous support groups.**
7. **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.
8. **Autopsies** and related charges.
9. **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.
10. **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.
11. **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.
12. **Claim Forms.** Expenses for completion of claim forms or for preparation of medical reports, or for missed appointments.
13. **Clergy.** Services of the clergy.
14. **Coma stimulation programs.**
15. **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.

16. **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.
17. **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.
18. **Custodial or Maintenance Care.** Custodial Care or domiciliary care, Maintenance Care, rest cures, convalescent care, a place for the aged or a nursing home.
19. **Dental Care.** Dental care (**EXCEPT** for any dental procedures specifically covered by this Plan).
20. **Duplicate.** Duplicate services or supplies.
21. **Durable Medical Equipment.** 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.
22. **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.
23. **Environmental Change.** Inpatient confinement, when such confinement is primarily for environmental change or rest.
24. **Excess of Maximum Benefit.** Charges in excess of any maximum benefit stated in the Plan.

25. **Excess of Usual, Customary and Reasonable Fee.** For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
26. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
27. **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.
28. **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.
29. **Family Counseling.** Family counseling, unless Medically Necessary or the family counseling is part of Medically Necessary treatment for a minor child Plan Member that has been recommended by a Health Care Professional treating the minor child.
30. **Financial or legal** counseling services.
31. **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.

- 32. **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.
- 33. **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.
- 34. **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.
- 35. **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.
- 36. **Hair Pieces.** Wigs and artificial hair pieces, unless related to a Sickness or Injury covered by this Plan.
- 37. **Halfway houses, wilderness programs,** group homes, or summer camps.
- 38. **Hearing Care.** Routine hearing care, except as stated otherwise under Preventive Care.
- 39. **Hemantinics.**
- 40. **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.
- 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, related services, unless specifically stated otherwise.

- 52. **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.
- 53. **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).
- 54. **Not Recommended.** For any service or supply which is not recommended or approved by a Physician.
- 55. **Nurse Midwife.** Delivery services of a certified Nurse Midwife when performed at an unlicensed, unaccredited facility.
- 56. **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.
- 57. **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.
- 58. **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).
- 59. **Penile prosthesis/implants.**
- 60. **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.
- 61. **Personal Growth.** Expenses for personal growth/development, hypnotherapy, holistic medicine or other programs with an objective to provide complete personal fulfillment.

62. **Prescription Drugs/Medications.** Unless stated otherwise, medications and vitamins which may be purchased without a Physician's written prescription (over-the-counter medications), and food supplements. Drugs, biologicals and solutions not listed in the latest edition of the United States Pharmacopoeia, the National Formulary or the New and Non-Official drugs. Prescription drugs received on an Outpatient basis are limited to the benefits specifically described under the Prescription Drug Card Benefit, except as specifically stated otherwise.

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

63. **Prior to Effective Date.** Charges Incurred prior to a Plan Member's Effective Date under the Plan.
64. **Private Duty Nursing** services.
65. **Professional Certifications.** Charges for professional certification, licensure or the like.
66. **Prohibited by Law.** Services that are prohibited by law or regulation.
67. **Recreational Therapy.**
68. **Respite Care.** Respite Care, except as specifically listed in the Hospice Care benefit.
69. **Reversal of Sterilization.** Charges for reversal of a sterilization procedure.
70. **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.
71. **Self-care and self-help training.**
72. **Sensory integration deficit therapy.**
73. **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.
74. **Social Worker.** Services of a social worker.

75. **Surrogacy** related to in connection with adoption.
76. **Taxes.** Charges for taxes or surcharges, other than those that a medical facility is legally required to make.
77. **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].
78. **Third Party Exams.** Physical examinations for research or obtaining licensure, employment or insurance.
79. **Tomosynthesis.**
80. **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.
81. **Transsexual Surgery.** Charges Incurred for transsexual Surgery and for any treatment leading to or in connection with sexual transformation.
82. **Transportation.** Expenses related to transportation to or between healthcare facilities, except as specifically provided under the Ambulance benefit.
- Non-Emergency Ambulance services.
83. **Travel.** Travel or accommodations for health, whether or not recommended by a Physician.
84. **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.

85. **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.

Drugs or medications of any kind related to Routine vision services.

86. **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.

87. **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.

88. **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.

89. **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)
- Complex Imaging services: CT/PET/MRI/MRA/SPECT
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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:

PPO: \$500 per service or
Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

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 or facility
5. Reason for the hospitalization or procedure
6. Date the hospitalization or procedure started or is scheduled
7. Employer's I.D. Number.

Exclusive Surgeries Solutions LLC (ESurgeries) – Surgical Management Program

You can save money and obtain better outcomes by participating in the Plan's Exclusive Surgeries Solutions LLC (ESurgeries) Surgical Management Program. The Plan has contracted with ESurgeries to provide you with a unique voluntary surgical management program. ESurgeries contracts with top area surgeons and imaging providers to perform many different surgical and complex imaging procedures in ambulatory care centers rather than in outpatient hospitals. ESurgeries' contracted case rates guarantee that the patient will have ***no out-of-network claims***, and, when the patient participates in this voluntary program, ***the Plan waives all cost shares***, including deductible and coinsurance. If the participant agrees to participate, the Plan staff will assist him or her to enroll and ESurgeries will work with him or her to schedule all appointments and follow-ups. If the participant chooses not to participate, the matter is referred back to the Plan's utilization review vendor to complete the pre-certification. If you are going to have a surgical procedure or complex imaging service covered by the ESurgeries program, as part of the Plan's pre-certification of the procedure, ESurgeries or the Plan Office will contact you to explain the program and help you enroll, help schedule your appointments, and make sure you have everything you need post-surgery to make a full and speedy recovery.

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. **Acupuncture.** Acupuncture services from licensed Acupuncture Health Care Providers.
2. **Allergy Testing, Injections and Serum.** Allergy testing, injections and serum when rendered by a Physician or Health Care Professional.

3. **Ambulance Services.** 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.

4. **Anesthetics.** Anesthetics and their administration when rendered in connection with an eligible surgical procedure and when administered by an anesthesiologist, anesthesiologist, Physician or by a registered nurse (under supervision of a Physician).
5. **Autism.** Charges for the treatment of Autism.
6. **Birthing Centers.** Charges made by a Birthing Center are covered on the same basis as if the charges had been made by a general Hospital.
7. **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.
8. **Chiropractic Care.** Includes x-rays, manipulations and supportive care. Supportive care means treatment, which is Medically Necessary to prevent the Plan Member's condition from significantly deteriorating. Maintenance care is Routine and is not Medically Necessary for the treatment of a condition. Maintenance care is **NOT** covered by the Plan. Chiropractic care is payable and **LIMITED** as shown in the Schedule of Coverage.
9. **Circumcisions.** Circumcisions (including Routine circumcisions) and the related charges for all male Plan Members.
10. **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 PPO Plan, as shown on the Schedule of Coverage, a Qualified Individual who wishes to participate in an Approved Clinical Trial must use a PPO Provider if a PPO Provider is participating in the trial and the PPO Provider accepts the Qualified Individual as a participant in the trial. However, if a Plan Member is covered under a PPO Plan, and the Approved Clinical Trial is either conducted outside the state in which the

Qualified Individual resides by a Non-PPO Provider or there is no PPO 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 PPO 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.

11. **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.

c. Medically Necessary treatment of temporomandibular disorder (TMJ/TMD), up to a \$300 Maximum Lifetime Benefit under the Plan, Including:

- i. Non-surgical treatment:
 - medical management pain relief;
 - “trigger point” injections;
 - physical therapy;

- cognitive behavioral therapy;
 - relaxation therapy, Including biofeedback;
 - Botox injections.
 - ii. Surgical treatment to correct functional problems of the jaw:
 - oral maxillofacial surgery;
 - orthognathic surgery, Including occlusal equilibration.
12. **Diabetic Education.** Diabetic education and training for self-management programs for Plan Members with diabetes.
13. **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.
14. **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.
15. **Home Health Care Agency.** 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.

16. **Hospice Care.** Charges made for Hospice Care when performed as part of a Hospice program are included as Covered Expenses. Hospice Care is care rendered to a Terminally Ill Plan Member by or under arrangements with a Hospice Agency.

Covered charges by a Hospice facility, Hospital, convalescent facility or Hospice Agency shall include:

- a. Room and board and services/supplies furnished to a Plan Member while an Inpatient for pain control and other acute and chronic symptom management; and
- b. The following services and supplies furnished to a Plan Member while not confined as an Inpatient.
 - i. Part-time or intermittent nursing care by a registered nurse (RN), licensed practical nurse (LPN) or home health aide for up to 8 hours in any day.
 - ii. Medical social services provided to the Hospice patient and his/her Immediate Family:

- a) Assessment of the Plan Member's social, emotional and medical needs, and the home and family situation.
- b) Identification of the community resources which are available.
- c) Assisting the Plan Member in obtaining those resources needed to meet his/her assessed needs.
- d) Psychological and dietary counseling.
- e) Consultation or case management services by a Physician.
- f) Physical and occupational therapy.
- g) Medical supplies, drugs, and medicines prescribed by a Physician.
- h) Bereavement counseling provided by a licensed social worker or a licensed pastoral counselor. Benefits are limited to the maximums set forth in the Schedule of Coverage.
- i) Benefits for Respite Care are limited to five days during which twelve or more hours of respite services are provided.

Not included are charges made for:

- a. Funeral arrangements.
- b. Financial or legal counseling which includes estate planning or the drafting of a will.
- c. Homemaker or caretaker services which are not solely related to care of the Plan Member, including sitter or companion services for either the Plan Member who is ill or other members of the family, transportation, housecleaning and maintenance of the house.
- d. Pastoral counseling.

17. **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 or provided the Hospital **ONLY** has private rooms). 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. If the Hospital only has private rooms, the Plan will consider as a Covered Expense an amount equal to the Hospital's least expensive room rate.

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.

18. **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.

19. Medical foods and Amino Acid-based Formula.

- a. Medical foods: The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Member per Coverage Year.
- b. Amino acid-based formula: The maximum annual benefit for amino acid-based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Member per Coverage Year.

20. 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, when prescribed by a Health Care Professional.

- a. home renal dialysis equipment and supplies;
- b. equipment necessary to treat respiratory failure;
- e. diabetic supplies (i.e., insulin, insulin syringes/needles, test tape and chemstrips), including insulin infusion pumps, only to the extent that these items are not covered under the Prescription Drug Card Benefit. Insulin pumps are limited to one insulin pump per Plan Member per Calendar Year;
- f. blood glucose monitoring devices for diabetic Plan Members, only to the extent that these items are not covered under the Prescription Drug Card Benefit (limited to one blood glucose monitoring device per Plan Member per Calendar Year);
- g. blood pressure monitoring equipment;
- h. inhalation devices;
- i. apnea monitoring devices;
- j. oxygen and other gases including rental of equipment for their administration.
- k. equipment and supplies used in connection with parenteral and intravenous therapy covered by the Plan;
- l. Jobst sleeves, stockings and gloves are covered only for post-phlebotic conditions or post-surgical edema, and coverage is limited to one item per affected body part per Coverage Year unless the item has outlived its useful life or must be replaced to accommodate bodily growth. (maximum benefit of 2 (two) per Plan Member per Coverage Year);

- m. wigs and artificial hair pieces worn for hair loss resulting from alopecia areata or other Sickness or Injury covered by the Plan;
- n. bronchial drainage systems that employ a chest percussion vest and vest compressor;
- o. bone growth stimulators;
- p. post mastectomy bras that accommodate a breast prosthesis (maximum benefit of 7 (seven) bras per Plan Member per Coverage Year);
- q. Home cervical traction unit;
- r. Light therapy devices for seasonal affective disorders and dermatologic conditions;
- s. the first purchase of glasses or contacts for aphakia, keratoconus or following cataract Surgery.
- t. Hearing aid (limit of 1 per Plan Member per Calendar Year).
- u. the purchase, fitting, adjustments and repairs of prosthetic devices and supplies that:
 - i. Replace all or part of a missing body part and its adjoining tissues;
 - ii. Aid in the function of a malfunctioning body part.

Repair or replacement of the above will be covered only if it is shown that the repair or replacement is due to a change in the Plan Member's physical condition or it is less costly to buy a replacement than to repair the existing prosthesis.

- v. Orthotics
- w. Disposable supplies and other supplies customarily provided by prescription and Medically Necessary for the treatment of a Sickness or Injury, including but not limited to needles, syringes, surgical dressings, casts, splints, slings trusses, ostomy and colostomy supplies, catheters, and other similar items which serve only a medical purpose, unless covered under the Prescription Drug Card Benefit. Items usually stocked in the home for general use, such as adhesive bandages, petroleum jelly and thermometers are not covered.
- x. Rental (not to exceed the purchase price) or purchase (at the Plan's option) of **Durable Medical Equipment**. Covered Expenses for Durable Medical Equipment which are prescribed by a Physician will be covered while the Plan Member is receiving medical care. Covered Expenses are limited to the least expensive item, which is adequate for the Plan Member's needs.

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.

- y. Medically Necessary **supplies used with covered medical equipment.**
- z. **Mechanical medical devices** placed in a body cavity to replace an internal organ or to aid the function of a body part, including but not limited to: pacemakers, artificial larynx, artificial hips and artificial knees.

- 21. **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.

22. **Organ/Tissue Transplant Services.**

Autologous. When the source of cells is from an individual's own marrow or stem cells.

Allogeneic. When the source of cells is from a related or unrelated donor's marrow or stem cells.

Autologous Bone Marrow Transplant. When bone marrow is harvested from the individual and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is then re-infused (transplanted).

Allogeneic Bone Marrow Transplant. When bone marrow is harvested from a donor and stored. The patient undergoes treatment which includes tumor ablation with high-dose chemotherapy and/or radiation. The bone marrow is re-infused (transplanted).

Autologous/Allogeneic Stem Cell Support. A treatment process that includes stem cell harvest from either bone marrow or peripheral blood, tumor ablation with high-dose chemotherapy and/or radiation, stem cell re-infusion, and related care. Autologous/allogeneic bone marrow transplantation and high dose chemotherapy with peripheral stem cell rescue/support are considered to be autologous/allogeneic stem cell support.

Transplant Services. This is transplantation including re-transplants of the human organs or tissue listed below including all related post-surgical treatment and drugs and multiple transplants for a related cause. Transplant services do not include other organ or tissue transplants or surgical implantation of mechanical devices that function as a human organ, except surgical implantation of FDA approved Ventricular Assist Devices (VAD), functioning as a temporary bridge to heart transplantation.

Covered Services include services, supplies, Inpatient medications, and related aftercare (Including procedures to determine rejection or success of transplant) for **ONLY** the following human organ and bone marrow transplants and stem cell support procedures **expressly listed below**:

- a. Autologous Bone Marrow Transplant;
- b. Allogeneic Bone Marrow Transplant;
- c. Autologous/Allogeneic Stem Cell Support;

- d. heart, heart-lung, liver, lung (single or double), for end-stage kidney disease, and cornea transplants for end stage disease;
- e. partial organ transplants, including partial liver or partial pancreas;
- f. pancreas transplant for a diabetic with end-stage renal disease who has received a kidney transplant or will receive a kidney transplant during the same operative sessions or a medically uncontrollable, labile diabetic with one or more secondary complications, but whose kidneys are not seriously impaired.

Organ/tissue transplant service means any of the following services, which are Medically Necessary, and rendered to a Plan Member as such services relate to a covered organ/tissue transplant:

- a. Organ/tissue procurement (including typing and acquisition);
- b. Medical supplies/services and room and board in a Hospital or in an alternate treatment setting approved by the Plan;
- c. Drugs and Physician charges; and.
- d. Transportation, lodging and meals in relation to a covered organ transplant (limited to the Plan Member and one companion and the donor; applies only when the Plan Member receiving the transplant or the donor resides more than 50 miles from the transplant facility). There is a maximum lifetime benefit of \$10,000.00 per Plan Member for transportation, lodging and meals in relation to an organ transplant.

Donor Expenses:

If a transplant operation is determined to be a covered organ/tissue transplant procedure, Covered Expenses Incurred by a **donor** will be covered as follows:

- a. if the donor is not a Plan Member, but donates to a Plan Member, this Plan will be secondary to any other plan under which the donor is entitled to benefits for these expenses.
- b. if the donor is covered by this Plan, but the recipient is not, the recipient's plan will be primary for the donor's expenses and this Plan will be secondary. ***THE RECIPIENT IS NOT ENTITLED TO BENEFITS UNDER THIS PLAN UNLESS HE/SHE IS A COVERED PLAN MEMBER.***

- c. if both the donor and the recipient are covered by this Plan, all Covered Expenses Incurred by each person will be treated separately for each person.

The following are not Covered Services under the Plan:

- a. services, chemotherapy, supplies, drugs and aftercare for or related to organ and bone marrow transplant and stem cell support procedures not specifically listed above as Covered Services;
- b. charges associated with the purchase of any organ;
- c. artificial organs, devices, or systems, whose purpose is to assist or replace a natural body organ, and any charges for the implantation, attachment or use of such organ, device or system, including follow-up care. This exclusion does not apply to kidney dialysis or pacemakers or cochlear implants. This exclusion does not apply to healthcare services or surgery for immediate life-threatening health problems as determined by the Plan or to charges in relation to artificial organs that may be necessary on a temporary short-term basis until a suitable donor organ is available;
- d. high dose chemotherapy with Autologous bone marrow transplantation to treat breast cancer;
- e. charges in connection with non-human organ or tissue transplants;
- f. services or supplies furnished in connection with the transportation of a living donor;
- g. travel expenses, except as stated above;
- h. re-transplants within a 365 day period following the original transplant procedure.

23. **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**.

24. **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, telehealth 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.

25. **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		
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.

26. **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.

27. **Skilled Nursing Facility.** 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.

28. **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.

29. **Telehealth Services.** Telehealth services which are Medically Necessary to diagnose or treat an Injury or Sickness.

30. **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.
31. **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

DEDUCTIBLE PROVISIONS

The Deductible amount can only be satisfied by Comprehensive Major Medical Covered Expenses. The Deductible applies to all Covered Expenses **UNLESS** specifically stated otherwise.

Once a family has collectively satisfied the family Deductible amount as shown in the Schedule of Coverage during a Calendar Year, no further Deductibles will be applied to Covered Expenses for other members of the family for the remainder of the Calendar Year.

The PPO Deductible will **NOT** be used to satisfy the Non-PPO Deductible, and vice versa.

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 Deductible amount and Coinsurance. The maximum is shown in the Schedule of Coverage.

The PPO Annual Out-of-pocket maximum will **NOT** be used to satisfy the Non-PPO 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

PPO OPTION

In order to receive benefits under the PPO Option, a Plan Member must receive treatment from a PPO provider. The Employer has PPO networks to offer health care services through specific Physicians, Hospitals and various other providers of service. The Plan offers a higher level of coverage for the expenses provided by PPO providers.

A listing of PPO network providers is available at no charge.

The Plan will pay for Covered Medical Expenses rendered by PPO providers based upon the approved amount of the charge by the PPO. Benefits are subject to the percentages listed in the Schedule of Coverage.

Responsibility for use of Preferred Providers

It is the Plan Member's responsibility to use preferred 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-PPO healthcare provider.

The following are the only additional circumstances in which the Plan Member will receive the higher level of benefits as specified in the Schedule of Coverage:

1. If Covered Services are not available through a PPO provider, then Non-PPO Covered Services will be paid at the PPO benefit level if Prior Authorization is obtained (the Plan Member will be responsible for the difference between the Usual, Customary, and Reasonable Fee and the billed charges).
2. If ancillary services and supplies (such as, but not limited to anesthesia, radiology, pathology, physical therapy, etc.) are rendered at a PPO facility regardless of whether the Physician or Health Care Professional providing the services is a PPO provider, provided however that the attending Physician is a PPO provider;
3. If the Plan Member is in an Emergency situation;
4. If treatment is received while traveling or residing outside the service area of the defined PPO provider network will be paid at the PPO percentage rate specified in the Schedule of Coverage.

NOTE: Non-PPO benefits will be paid for Covered Services incurred at a Non-PPO facility when admitted by a PPO Physician.

Continuity of Care.

Notwithstanding anything in this Plan to the contrary, in the event a Plan Member joins the Plan or a Health Care Professional ceases to be a PPO Provider, a Plan Member shall have the opportunity to continue receiving treatment from his/her Health Care Professional even though that Health Care Professional is not a PPO Provider as provided herein.

1. A new Plan Member may continue an active course of treatment for a life threatening disease or condition with a Health Care Provider who is not a PPO Health Care Provider for a transitional period of thirty (30) days from the effective date of the new Plan Member's coverage under the Plan.
2. In the event a new Plan Member has entered the third trimester of pregnancy, such new Plan Member may continue to receive care from a Health Care Professional who is not a PPO Health Care Professional for a transitional period beginning on the effective date of the new Plan Member's coverage under the Plan and ending upon the earlier of: (i) the cessation of care related to the delivery of the child, or (ii) six (6) weeks after the delivery.
3. A Plan Member may continue an active course of treatment for a life threatening disease or condition with a Health Care Professional who was terminated from the PPO for a transitional period of thirty (30) days from the date the Health Care Professional ceases to be PPO provider. In the event the Health Care Professional was terminated for reasons of medical incompetence or unprofessional conduct, this provision shall not apply.

In order for this continuity of care provision to apply, the Health Care Professional must agree in writing to accept, as payment in full, reimbursement at the rates established by the Plan, comply with the Plan's quality assurance and utilization review requirements, and comply with the Plan's policies and procedures relating to obtaining Prior Authorization. For a Health Care Professional who was terminated from the PPO, the rates shall be the rates applicable before the termination. For all other Health Care Professional, the rates shall not exceed the level of reimbursement applicable to similar services of Health Care Professional within the PPO. The Plan will not provide coverage for benefits not otherwise covered under this Plan.

SECTION L

PRESCRIPTION DRUG CARD BENEFIT

For additional information, please refer to the material provided by the Prescription Drug Card Administrator or contact them at the phone number listed on the prescription drug card. The Prescription Drug Card Administrator will be able to assist the Plan Member in determining the benefits, limitations and exclusions relative to the prescription drug card program, which may differ from the benefit, limitations and exclusion in this Plan.

SECTION M

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 trustee 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 an 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 N

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 cannot 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 O

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 PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

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 P

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 Q

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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

SECTION R

COVID-19

The Plan will provide enhanced health benefits associated with testing and vaccination administration for the 2019 Novel Coronavirus (COVID-19). Diagnostic laboratory testing for COVID-19 and vaccine administration charges shall be eligible and paid with no cost-sharing.

The above benefits are specific to testing/prevention of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

This Plan shall at all times be in compliance with any required benefits or procedures mandated under the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), or as later amended, provided the Employer is required to comply with such acts.

**City of San Luis
EMPLOYEE BENEFIT TRUST DENTAL BENEFIT PLAN**

**PLAN DOCUMENT and
SUMMARY PLAN DESCRIPTION**

90 DEGREE BENEFITS GROUP NUMBER: SLS0001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, the Plan Sponsor establishes City of San Luis Employee Benefit Trust Dental Benefit Plan (the "Plan") to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Plan Sponsor's previous plan of dental 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

90 Degree Benefits, 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.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

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 Dental Benefit Plan in order to provide comprehensive dental benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust Dental Benefit Plan is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Dental 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 Dental 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 Dental Plan are not taxable income to the Employee. This Dental 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 Dental 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 Dental Plan
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
Plan Number:	501

90 Degree Benefits Group Number:	SLS001
Type of Administration:	Self-funded Dental 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 Dental Plan.
Name of Trust	City of San Luis Employee Benefit Trust
Trustees	For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust
Claims Administrator:	90 Degree Benefits, Inc. 215 Stanford Pkwy Findlay, OH 45840 Phone Number 800-558-7798 Please Note: 90 Degree Benefits, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Dental Plan.
Agent for Legal Services:	City of San Luis 1090 E. Union Street San Luis, AZ 85349 928-341-8547

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, USUAL, CUSTOMARY AND REASONABLE FEES 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.

DENTAL BENEFITS

Calendar Year Deductible	
Class I Services	NONE
Class II, III and IV Services	
Individual	\$25
Family	\$50
Payment Percentages after Deductible is met	
Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	80%
Class III Services - Major Services	50%
Class IV Services – Orthodontics	50%
Maximum Benefits	
Per Calendar Year for Class I, II & III Services, combined	\$2,000
Per Lifetime for Class IV Services	\$2,000
Carryover Provision	
Applies Per Calendar Year for Class I, II & III Services	\$250

If a Plan member does not exceed 75% (\$1,500) of the yearly maximum benefit in one Calendar Year, \$250 may be carried over into the following year, for a maximum benefit of up to \$2,250 per Calendar Year for Class I, II & III Services, combined. Carryover does not apply to Class IV Services.

If Covered Services are rendered in Mexico and in the United States in one Calendar Year, the Maximum Calendar Year benefit paid by the Dental Plan is \$2,000. Only \$1,000 of the Covered Services can be rendered in Mexico in the Calendar Year, and a Preferred Network Provider must be utilized for those Covered Services provided in Mexico.

If Orthodontia treatments that are Covered Services have started in Mexico, the treatment must be completed in Mexico. Orthodontia treatment completed in the United States will not be a Covered Service if the treatment started in Mexico.

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available.

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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 Dental Provider's relationship with the Plan and/or the dental services provided.

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

CALENDAR YEAR MAXIMUM BENEFIT means the total dollar amount of Covered Expenses a Plan Member may receive during a Calendar Year while enrolled under this Dental Plan. The Maximum Calendar Year Benefit does not include amounts which are the Plan Member's responsibility.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services until the Calendar Year Maximum Benefit 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 Dental Provider. In other instances, the Plan Member will be billed by the Dental Provider. These arrangements are between the Plan Member and the Dental Provider.

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. This Dental Plan's Coverage Year is January 1 through December 31.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible 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.

COVERED SERVICE means Dental Services described in the Schedule of Coverage section for which Dental Plan benefits will be provided, unless limited or excluded in the Exclusions section of this Dental Plan. A Covered Service is incurred on the date the Dental Service is received.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

DENTAL PROVIDER means professional Dental Providers providing dental services to Plan Members. Each Dental Provider must be licensed, registered or certified by the appropriate state agency where the dental services are performed. Where there is no appropriate state agency, the Dental Provider must be registered or certified by the appropriate professional body. Dental Provider Includes those listed below:

1. **DENTIST** - a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).
2. **ORTHODONTIST** – a Dentist who has been specially trained to do orthodontics.
3. **DENTAL HYGIENIST** - a duly licensed Dental Hygienist who works under the supervision of a Dentist.

DENTAL SERVICES means the provision of all dental treatment as defined in the Dental Plan.

DENTALLY NECESSARY means dental care services, supplies or treatment, which are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.

3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.
4. Not primarily for the convenience of the Plan Member's family or the Dentist.
5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does **NOT** in itself make it eligible for payment.

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.

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

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. Employee also included Council Members who are working a minimum of 20 hours per month.

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.

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.

IMMEDIATE FAMILY means the Plan Member's spouse, parent, child, stepchild, foster child, legally adopted child, grandchild, sister, brother, grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

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.

LIFETIME wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does "**Lifetime**" mean during the lifetime of the Plan Member.

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.

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

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible 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 dental medicine 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 MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

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.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, or Employer, 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).

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.

SICKNESS means a disorder of the body, disease, or condition.

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.

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.

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, Dental, 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 Dental) 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
90 Degree Benefits, 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.
- 4. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retired Employee ends on the date of the covered retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the surviving spouse or Dependent child of the covered retired Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the covered retired Employee.

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
90 Degree Benefits, 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
90 Degree Benefits, 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.).

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, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, 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

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, dental procedures or supplies, regardless of Dental Necessity or recommendation by a Dental Provider. The Plan Member is responsible for 100% of the expenses associated with the listed exclusions. These expenses are not Covered Services and, therefore, will not count toward the Annual Out-of-Pocket Maximum.

1. Charges for any device ordered while the Plan Member was covered under this Dental Plan and not delivered or installed within thirty (30) days after termination of coverage.
2. Replacement of duplicate, lost missing or stolen appliances or prosthetic devices.
3. Charges for all services, supplies and treatment related to dental implants.
4. Any procedure not listed as a Covered Service.
5. Any procedure that began before the date the Plan Member's dental coverage started to include a service which is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered under the Dental Plan;
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered under the Dental Plan;
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered under the Dental Plan.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspid are considered optional, and as such, are not Covered Services.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.
9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.
10. A service not furnished by a Dentist, except;
 - a. That performed by a licensed dental hygienist under a Dentist's supervision;
 - b. X-rays ordered by a Dentist; and
 - c. Denturist.
11. Charges for over-dentures, Including related root canal therapy and supportive restorations.
12. Replacement of a prosthetic which in the Dentist's opinion can be repaired or does not need replacement.
13. Fixed prosthetics and/or partials for Plan Members through the age of fifteen. An allowance will be made for a temporary acrylic partial.
14. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
15. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
16. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required Dental Services.
17. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for Plan Members through the age of fifteen (15). An allowance will be made for an acrylic crown.
18. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
19. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

20. Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for telephone consultations.
21. 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.
22. Charges in excess of any maximum benefit stated in the Plan.
23. For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
24. 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.
25. 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 for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
26. 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.
27. 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.
28. Charges for taxes or surcharges, other than those which a medical facility is legally required to make.

SECTION H

DENTAL BENEFITS

Covered Dental Expenses

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for the following dental services, only when performed by a Dentist or a Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan.

Class I Services -Preventive and Diagnostic Services

D0120	Follow up exam every 6 months
D0140	Emergency exam
D0145	Oral evaluation for a patient under age 3/counseling with primary caregiver
D0150	Initial oral exam
D0160	Detailed and extensive oral evaluation-problem focused, by report
D0170	Re-evaluation limited problem focused (established patient)
D0210	Intraoral complete series (including Bitewings)
D0220	Intraoral single/first film
D0230	Intraoral periapical each additional film
D0240	Intraoral occlusal film each
D0270	Bitewing single film
D0272	Bitewings - two films
D0273	Bitewings - three films
D0274	Bitewings - four films
D0277	Vertical bitewings
D0330	Panoramic radiographic image
D0431	Adjunctive pre-diagnostic test (mucosal lesions)
D1351	Apply sealant per tooth
D1110	Adult prophylaxis
D1120	Child prophylaxis
D1208	Topical application of fluoride
D2910	Re-cement inlay
D2920	Re-cement crown
D2940	Sedative filling
D2950	Core buildup, including any pins
D9223	Deep sedation/general anesthesia-each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9910	Application of desensitizing medicament

Class I Services – Limitations

- Teeth cleaning - limited to 2 times per Calendar Year
- Exams - limited to 2 times per Calendar Year
- Dental x-rays
 - Full or Panoramic - limited to once in any 36 consecutive month period
 - Bitewings films, maximum of 4 films per visit - limited to 2 sets of x-rays perCalendar Year
 - Vertical bitewing x-rays- limited to 1 set every 3 years
- Fluoride treatments - limited to children under age 16 and to 1 treatment perCalendar Year
- Sealants - limited to unrestored permanent molars of Plan Members under 16years of age and to one treatment per tooth in any 36 consecutive months
- Office visits, during regular hours - problem focus exams - limited to 2 visits perCalendar year

Class II Services - Basic Services

D0322	Tomographic survey
D0480	Accession of exfoliative cytologic smears (written report)
D1510	Space maintainer - fixed bilateral
D1515	Space maintainer - fixed unilateral
D2140	Amalgam one surface/permanent or primary
D2150	Amalgam two surface/permanent or primary
D2160	Amalgam three surface/permanent or primary
D2161	Amalgam four surface/permanent or primary
D2330	Composite resin one surface anterior
D2331	Composite resin two surface anterior
D2332	Composite resin three surface anterior
D2335	Composite resin four or more surfaces
D2390	Resin based composite crown, anterior
D2391	1 surface resin based composite
D2392	2 surface resin based composite
D2393	3 surface resin based composite
D2394	4 or more surface resin based composite
D2954	Post & core
D2957	Each additional prefabricated post- same tooth
D2960	Labial veneer (resin laminate)- chairside

D2961 Labial veneer (resin laminate)- laboratory
 D2962 Labial veneer (porcelain laminate)- laboratory
 D3110 Pulp cap - direct (excluding final restoration)
 D3120 Pulp cap - indirect (excluding final restoration)
 D3220 Therapeutic pulpotomy (excluding final restoration)
 D3221 Pulpal debridement primary and permanent
 D3230 Pulpal therapy- anterior, primary tooth
 D3240 Pulpal therapy- posterior, primary tooth
 D3310 Anterior root canal
 D4211 Gingivectomy/plasty- one to three contiguous teeth, per quadrant
 D4240 Gingival flap procedure - four or more contiguous teeth/spaces per quadrant
 D4341 Periodontal scaling & root planning per quadrant
 D4342 Periodontal scaling and root planing - one to three teeth per quadrant
 D4355 Full mouth debridement
 D4910 Periodontal maintenance, following active therapy
 D5650 Add tooth to existing partial denture
 D5660 Add clasp to existing partial denture
 D5710 Rebase complete lower denture
 D5711 Rebase complete upper denture
 D5720 Rebase upper partial denture
 D5721 Rebase lower partial denture
 D5730 Reline complete upper denture (chairside)
 D5731 Reline complete lower denture (chairside)
 D5740 Reline upper partial denture (chairside)
 D5741 Reline lower partial denture (chairside)
 D6930 Recement fixed partial bridge
 D7111 Extraction baby tooth
 D7140 Extraction erupted tooth (adult)
 D7210 Surgical removal erupted tooth
 D7220 Soft tissue impaction
 D7230 Partially bony impaction
 D7250 Surgical removal of residual tooth roots (cutting procedure)
 D7910 Suture recent small wound (5cm)
 D7950 Osseous, osteo perio graft
 D7960 Frenulectomy

Class III Services - Major Dental Repair Services

D2642 Onlay- porcelain/ceramic - 2 surface
 D2643 Onlay- porcelain/ceramic - 3 surface
 D2644 Onlay- porcelain/ceramic - 4 surface
 D2722 Crown - resin with noble metal
 D2740 Crown - porcelain/ceramic

D2750 Crown - porcelain w/gold
 D2751 Crown- porcelain fused to predominantly base metal
 D2752 Crown - porcelain fused to noble metal
 D2790 Gold (full cast) crowns
 D2799 Provisional crown-temporary restoration of least six months
 D2930 Stainless crown (primary)
 D2931 Stainless steel crown-pert tooth
 D2932 Prefabricated resin crown
 D3320 Bicuspid root canal
 D3330 Root canal therapy - molar
 D3346 Retreatment root canal anterior (one root)
 D3347 Retreatment root canal bicuspid (two roots)
 D3348 Retreatment root canal molar (three roots)
 D3410 Apicoectomy (per tooth) anterior
 D3421 Apicoectomy/periradicular surgery - bicuspid
 D3425 Apicoectomy/periradicular surgery - molars
 D3426 Apicoectomy/periradicular surgery- (each additional root)
 D4210 Gingivectomy/plasty- four or more contiguous teeth, per quadrant
 D4241 Gingival flap procedure - one to three contiguous teeth/spaces per quadrant
 D4249 Clinical crown lengthening - hard tissue
 D4260 Osseous surgery- four or more contiguous teeth/spaces per quadrant
 D4261 Osseous surgery- one to three contiguous teeth/spaces per quadrant
 D4263 Bone replacement graft-retained natural tooth-first site in quadrant.
 D4264 Bone replacement graft - multisite
 D4273 Subepithelial tissue graft procedure subepithelial
 D4321 Provisional splinting-extra coronal
 D5110 Complete denture, upper - once every 5 years
 D5120 Complete denture, lower - once every 5 years
 D5130 Immediate upper dentures - lifetime benefit
 D5140 Immediate lower dentures - lifetime benefit
 D5211 Maxillary partial denture/resin base
 D5212 Mandibular partial denture/resin base
 D5213 Upper partial denture/metal frame work w/resin
 D5214 Lower partial denture/metal frame work w/resin
 D5281 Remove unilat part/one piece cast metal
 D5820 Interim partial denture (upper)
 D5821 Interim partial denture (lower)
 D6242 Pontic - porcelain fused to noble metal
 D6740 Crown- porcelain
 D6750 Crown - porcelain fused to high noble metal
 D6751 Crown - porcelain fused to predominantly base metal
 D6752 Crown - porcelain fused to noble metal
 D7240 Completely bony impaction
 D7241 Removal of impacted tooth - completely bony
 D7272 Surgical tooth transplantation

D7286 Biopsy of oral tissue - soft
D7472 Removal of torus palatinus
D7473 Removal of torus mandibular
D7485 Surgical reduction of osseous tuberosity

Class III Services -Limitations

- Denture repairs, adjustments, relines or rebase - limited to adjustments made morethan 6 months after the initial installation. Rebase is limited to once per 36 consecutive month period. Reline is limited to once per 12 consecutive month period.
- Complete and partial dentures. Immediate dentures are limited to one set per Lifetime.

NOTE: The Plan covers the replacement of an existing denture or bridge onlyif the existing denture or bridge is unserviceable and cannot be made serviceable. The Plan pays the benefit level that applies to the cost of services necessary to make the appliances serviceable. The plan will cover replacement of prosthodontic appliances only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

Class IV Services - Orthodontic Services.

NOTE: Dependent children must be covered under the Dental Plan for twelve (12)consecutive months before orthodontia benefits are available.

D0340 Cephalometric film
D0350 Panoramic film
D0470 Diagnostic cast
D8030 Limited orthodontic treatment of the adolescent dentition
D8670 Periodic orthodontic treatment visit cast part of contract

Any other Class I, II or III services that are performed in connection with orthodontic treatment shall be payable under their appropriate payment percentage and not included under the orthodontic limitations and/or payment percentages.

Carryover Provision

If a Plan member does not exceed 75% (\$1,500) of the yearly maximum benefit for Class I, II & III Services in one Calendar Year, \$250 may be carried over into the following year, for a maximum benefit of up to \$2,250 per Calendar Year for Class I, II & III Services, combined. Carryover does not apply to Class IV Services.

SECTION I

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. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year for each claim as it is submitted had it been the Plan 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 trustee 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 person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

1. secondary to the Plan covering the person as a dependent; and
2. primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee);

then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

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 an

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 J

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 cannot 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 K

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 A 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/Dentist or surgeon, and the Physician/Dentist-patient relationship shall be maintained. The Plan Member, together with his Physician/Dentist, is ultimately responsible for determining the appropriate course of dental treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO 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.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, 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/dental expense benefits payable under this Plan shall be paid to the medical/dental service provider, unless the claimant furnishes proof of payment of the medical/dental expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant.

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 L

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 M

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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

**City of San Luis
EMPLOYEE BENEFIT TRUST – Mexico Coverage**

**SUMMARY PLAN DESCRIPTION AND
PLAN DOCUMENT**

90 DEGREE BENEFITS GROUP NUMBER: SLS001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, 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

90 Degree Benefits, 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.

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
90 Degree Benefits 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:

90 Degree Benefits, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: 90 Degree Benefits, 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:	\$4,500 INDIVIDUAL	Out-of-Network:	\$20,000 INDIVIDUAL
	\$9,000 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
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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 and only in the case of an Emergency. All other Out-of-Network providers are NOT covered.

NOTE: The following out-of-network services will be eligible expenses during the course of public health emergency relating to COVID-19 : Procedures and services through Exclusive Surgeries Solutions LLC; procedures and services through San Luis Walk in Clinic.

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.

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	Included in Emergency Copay	Included in Emergency Copay	Out-of-Network only covered in the case of Emergency.
COVID-19 tests and vaccine administration	100%	100%	Includes testing, related services, and vaccine administration to the extent required by law.
Dental Hospitalization and Dental Services Office Visits	100% after a \$25 Copay per visit	Not Covered	
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	100% after a \$5 Copay per visit	Hearing aids: 80% All other: Not Covered	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 (visit only)	100% after a \$150 Copay per visit 100% after a \$20 Copay per visit	100% after a \$150 Copay per visit Not Covered	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 Covered	Not Covered	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
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%	Out-of-Network only covered in the case of Emergency.
Inpatient and Outpatient Physician Services Primary Care Physician/Specialist Office Visits (includes lab and X-ray) Inpatient Visit Surgery (Physician's office) Surgery (other) Physician Services – Pathology, Anesthesiology , or Radiology	 100% after a \$5 Copay per visit 100% 100% 100% 100%	 Not Covered Not Covered Not Covered Not Covered Not Covered	
Maternity Prenatal visits Initial visit All other visits Hospital Services Birthing Centers	 100% after a \$5 Copay per visit 100% 100% after a \$50 Copay per visit Not available	 Not Covered Not Covered Not Covered Not Covered	

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Mental/Nervous Disorders and/or Substance Abuse Inpatient treatment Visits for more than 12 hours Visits for less than 12 hours Outpatient treatment	 100% after a \$50 Copay per visit 100% after a \$25 Copay per visit 100% after a \$5 Copay per visit	 50% 50% Not Covered	Inpatient treatment: Out-of- Network only covered in the case of Emergency.
Outpatient Diagnostic Tests Complex - MRI, CT, PET Scans Other X-rays and Laboratory tests	 100% after a \$25 Copay per visit 100% after a \$5 Copay per visit	 Not Covered Not Covered	
Outpatient Prescription Drugs Generic Drugs Name Brand Drugs	 100% after a \$2 Copay 100% after a \$5 Copay	 Not Covered Not Covered	
Preventive Care Services Pediatric and Adult Preventive Care Immunizations, inoculations, vaccinations Sterilization – limited to Employee and covered Spouse only	 100% 100% 100%	 Not Covered Not Covered Not Covered	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.

Benefit Description	Mexico Coverage SIARMED - Plan pays	Out-of-Network – US Healthcare Providers only - Plan Pays	Additional Limitations and Explanations
Rehabilitation and Habilitation Services	100% after a \$5 Copay per visit	Not Covered	Siarmed covered services in Mexico include physical and speech therapy only.
Skilled Nursing Facility	Not Covered	Not Covered	
All other Covered Expenses	100%	Not Covered	

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc, formerly EBSO, Inc.

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.

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. Employee also includes Council Members who are working a minimum of 20 hours per month.

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 times;
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 chiropractic, 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
90 Degree Benefits, 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
90 Degree Benefits, 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
90 Degree Benefits, 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, or for missed appointments.
 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 peripheral vascular 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
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

For Pre-Certification call 90 Degree Benefits 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:

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

This reduction is in addition to any Deductible or Copay.

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 or facility
5. Reason for the hospitalization or procedure
6. Date the hospitalization or procedure started or is scheduled
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 anesthesiologist, 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, telehealth 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.

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		
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. **Telehealth Services.** Telehealth services which are Medically Necessary to diagnose or treat an Injury or Sickness.

28. **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.
29. **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 trustee 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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

SECTION Q

COVID-19

The Plan will provide enhanced health benefits associated with testing and vaccination administration for the 2019 Novel Coronavirus (COVID-19). Diagnostic laboratory testing for COVID-19 and vaccine administration charges shall be eligible and paid with no cost-sharing.

The above benefits are specific to testing/prevention of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

Mexico Out-of-Network Healthcare Providers will be allowed as eligible based on Emergency status.

This Plan shall at all times be in compliance with any required benefits or procedures mandated under the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act), or as later amended, provided the Employer is required to comply with such acts.

**City of San Luis
EMPLOYEE BENEFIT TRUST DENTAL BENEFIT PLAN – Mexico Coverage**

**PLAN DOCUMENT and
SUMMARY PLAN DESCRIPTION**

90 DEGREE BENEFITS GROUP NUMBER: SLS0001

Effective: July 1, 2018

Revised and Restated: July 1, 2021

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ESTABLISHMENT OF THE MASTER PLAN DOCUMENT

Effective July 1, 2018, and revised and restated July 1, 2021, the Plan Sponsor establishes City of San Luis Employee Benefit Trust Dental 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 dental 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

90 Degree Benefits, 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.

Date

Signature

Print or Type Name and Title

Witness Signature

Print or Type Witness Name

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 Dental Benefit Plan – Mexico Coverage in order to provide comprehensive dental benefits for Employees, and their Dependents.

The City of San Luis Employee Benefit Trust Dental Benefit Plan – Mexico Coverage is a self-insured public sector plan within the meaning of Arizona Statute 11-981 (hereinafter “Plan”). The Dental 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 Dental 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 Dental Plan are not taxable income to the Employee. This Dental 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 Dental 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 Dental Plan – 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
Plan Number:	501
90 Degree Benefits Group Number:	SLS001
Type of Administration:	Self-funded Dental 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 Dental Plan.

Name of Trust

City of San Luis Employee Benefit Trust

Trustees

For current information on Trustees, please refer to the Agreement and Declaration of Trust for City of San Luis Employee Benefit Trust

Claims Administrator:

90 Degree Benefits, Inc.
215 Stanford Pkwy
Findlay, OH 45840
Phone Number 800-558-7798

Please Note: 90 Degree Benefits, Inc. performs claims processing services pursuant to a contract, it does not insure benefits under the Dental Plan.

Agent for Legal Services:

City of San Luis
1090 E. Union Street
San Luis, AZ 85349
928-341-8547

SECTION B

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO COPAYS, MAXIMUM BENEFIT PAYMENTS, USUAL, CUSTOMARY AND REASONABLE FEES 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.

DENTAL BENEFITS – NETWORK ONLY

Copays

Class I Services – Diagnostic and Preventive Care	None
Class II Services - Basic Services	\$5
Class III Services - Major Services	\$10
Class IV Services – Orthodontics	None
Pharmacy Rx	
Generic	\$2
Name Brand	\$5

Payment Percentages after Copay is met

Class I Services – Diagnostic and Preventive Care	100%
Class II Services - Basic Services	100%
Class III Services - Major Services	100%
Class IV Services – Orthodontics	50%

Maximum Benefits

Per Calendar Year for Class I, II, & III Services, combined	\$1,000
Per Lifetime for Class IV Services	\$1,000

Carryover Provision

Applies Per Calendar Year for Class I, II, & III Services, combined	\$125

If a Plan member does not exceed 75% (\$750) of the yearly maximum benefit in one Calendar Year, \$125 may be carried over into the following year, for a maximum benefit of up to \$1,125 per Calendar Year for Class I, II, & III Services, combined. Carryover does not apply to Class IV Services.

NOTE: Orthodontic Services are **LIMITED** to Dependent children less than 19 years of age. Dependent children must be covered under the Plan for 12 consecutive months before orthodontic services are available. Prior authorization for orthodontia services must go through SIARMED.

THE NETWORK IS ADMINISTERED BY: SIARMED

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.**

90 DEGREE BENEFITS means 90 Degree Benefits, Inc., formerly EBSO, Inc.

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 Dental Provider's relationship with the Plan and/or the dental services provided.

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

CALENDAR YEAR MAXIMUM BENEFIT means the total dollar amount of Covered Expenses a Plan Member may receive during a Calendar Year while enrolled under this Dental Plan. The Maximum Calendar Year Benefit does not include amounts which are the Plan Member's responsibility.

COINSURANCE means the charge a Plan Member must pay for certain Covered Services until the Calendar Year Maximum Benefit 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 Dental Provider. In other instances, the Plan Member will be billed by the Dental Provider. These arrangements are between the Plan Member and the Dental Provider.

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. This Dental Plan's Coverage Year is January 1 through December 31.

COVERED EXPENSES are charges for services that are covered under the Plan. Some charges, although eligible, may be subject to Deductible 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.

COVERED SERVICE means Dental Services described in the Schedule of Coverage section for which Dental Plan benefits will be provided, unless limited or excluded in the Exclusions section of this Dental Plan. A Covered Service is incurred on the date the Dental Service is received.

DEDUCTIBLE means the amount of Covered Expenses payable by the Plan Member each Calendar Year before benefits are paid by the Plan.

DENTAL PROVIDER means professional Dental Providers providing dental services to Plan Members. Each Dental Provider must be licensed, registered or certified by the appropriate state agency where the dental services are performed. Where there is no appropriate state agency, the Dental Provider must be registered or certified by the appropriate professional body. Dental Provider Includes those listed below:

1. **DENTIST** - a Doctor of Dental Surgery (D.D.S.), Oral Pathologist, Oral Surgeon or Doctor of Dental Medicine (D.M.D.).
2. **ORTHODONTIST** – a Dentist who has been specially trained to do orthodontics.
3. **DENTAL HYGIENIST** - a duly licensed Dental Hygienist who works under the supervision of a Dentist.

DENTAL SERVICES means the provision of all dental treatment as defined in the Dental Plan.

DENTALLY NECESSARY means dental care services, supplies or treatment, which are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.

3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.
4. Not primarily for the convenience of the Plan Member's family or the Dentist.
5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does **NOT** in itself make it eligible for payment.

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.

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

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. Employee also included Council Members who are working a minimum of 20 hours per month.

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.

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.

IMMEDIATE FAMILY means the Plan Member's spouse, parent, child, stepchild, foster child, legally adopted child, grandchild, sister, brother, grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law.

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.

LIFETIME wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does "**Lifetime**" mean during the lifetime of the Plan Member.

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.

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

PAYMENT PERCENTAGE means the amount payable by the Plan for Covered Expenses after satisfaction of the Deductible 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 dental medicine 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 MEMBER means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

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.

PROTECTED HEALTH INFORMATION (PHI) means health information that is created or received by a Covered Entity, or Employer, 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).

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.

SICKNESS means a disorder of the body, disease, or condition.

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.

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.

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, Dental, 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 Dental) 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
90 Degree Benefits, 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.
- 4. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retired Employee ends on the date of the covered retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the surviving spouse or Dependent child of the covered retired Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the covered retired Employee.

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
90 Degree Benefits, 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
90 Degree Benefits, 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.).

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, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, 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

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, dental procedures or supplies, regardless of Dental Necessity or recommendation by a Dental Provider. The Plan Member is responsible for 100% of the expenses associated with the listed exclusions. These expenses are not Covered Services and, therefore, will not count toward the Annual Out-of-Pocket Maximum.

1. Charges for any device ordered while the Plan Member was covered under this Dental Plan and not delivered or installed within thirty (30) days after termination of coverage.
2. Replacement of duplicate, lost missing or stolen appliances or prosthetic devices.
3. Charges for all services, supplies and treatment related to dental implants.
4. Any procedure not listed as a Covered Service.
5. Any procedure that began before the date the Plan Member's dental coverage started to include a service which is:
 - a. An appliance, or modification of an appliance, for which an impression was made before such person became covered under the Dental Plan;
 - b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered under the Dental Plan;
 - c. Root canal therapy, for which the pulp chamber was opened before such person became covered under the Dental Plan.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

6. Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or porcelains posterior to the second bicuspid are considered optional, and as such, are not Covered Services.
7. Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

8. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting or replacing tooth structure lost as a result of abrasion or attrition, except as provided under Orthodontic Services.
9. Charges for services, supplies or treatment for which benefits are payable under any employer sponsored group medical or dental plan.
10. A service not furnished by a Dentist, except;
 - a. That performed by a licensed dental hygienist under a Dentist's supervision;
 - b. X-rays ordered by a Dentist; and
 - c. Denturist.
11. Charges for over-dentures, Including related root canal therapy and supportive restorations.
12. Replacement of a prosthetic which in the Dentist's opinion can be repaired or does not need replacement.
13. Fixed prosthetics and/or partials for Plan Members through the age of fifteen. An allowance will be made for a temporary acrylic partial.
14. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.
15. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
16. Charges resulting from changing from one Dentist to another while receiving treatment, or from receiving care from more than one Dentist for one dental procedure, to the extent the total charges billed exceed the amount that would have been billed if one Dentist had performed all the required Dental Services.
17. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for Plan Members through the age of fifteen (15). An allowance will be made for an acrylic crown.
18. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
19. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

20. Expenses for completion of claim forms or for preparation of medical reports; for missed appointments or for telephone consultations.
21. 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.
22. Charges in excess of any maximum benefit stated in the Plan.
23. For expenses made which are in excess of the Usual, Customary and Reasonable Fee.
24. 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.
25. 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 for care or service furnished by a tax supported state Hospital for treatment of Mental/Nervous Disorders.
26. 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.
27. 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.
28. Charges for taxes or surcharges, other than those which a medical facility is legally required to make.
29. Charges for Out-of-Network services and providers.

SECTION H

DENTAL BENEFITS

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses incurred by a covered person. The dental benefit is a percentage of the customary and reasonable amount for incurred covered dental expenses, as shown on the Schedule of Benefits.

MAXIMUM BENEFIT

The maximum benefit year benefit payable on behalf of a covered person for covered dental expense is stated on the Schedule of Benefits. If the covered person's coverage under the Plan terminates and he subsequently returns to coverage under the Plan during the benefit year, the maximum benefit will be calculated on the sum of benefits paid by the Plan.

ALTERNATIVE TREATMENT

In the event the dentist recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the covered person's choice to obtain the higher-cost treatment will be the covered person's responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is incurred, except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the claims processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages.

No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Diagnostic and Preventive Dental Services

- I. Routine oral examination: Initial or periodic, limited to twice per benefit year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per benefit year.
3. Dental x-rays as follows:
 - a. Supplementary bite-wing x-rays limited to twice per benefit year.
 - b. Panorex or full mouth series limited to one of each every thirty-six (36) months.
 - c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for dependent children limited to one treatment per benefit year.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to dependent children. This does not include space maintainers used in orthodontics to create a space between teeth.
6. Topical application of sealant to permanent posterior teeth, for dependent children limited to one treatment per tooth every thirty-six (36) months.
7. Emergency palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Basic Dental Services

- I. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.
2. Restorations, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or injury.
3. Pin retention when part of the restoration instead of gold or crown retention.
4. Periodontics as follows:

- a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery.
 - b. Scaling and root planning limited to twice per quadrant in any benefit year.
 - c. Pedicle and free soft tissue grafts, and vestibuloplasty.
 - d. Occlusal adjustment, excluding charges for TMJ.
 - e. Excision of pericoronal gingiva.
 - f. Periodontal prophylaxis limited to twice per benefit year with proof of previous periodontal treatment.
 - g. Osseous surgery.
5. Endodontics as follows:
- a. Pulp Capping.
 - b. Pulpotomy.
 - c. Root canal therapy on permanent teeth only.
 - d. Apicoectomy.
 - e. Hemisection.
 - f. Retrograde fillings.
6. Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
- a. Simple extraction of one or more teeth.
 - b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
 - c. Extraction of tooth root.
 - d. Incision and drainage of a tumor or a cyst.
 - e. Alveolectomy, alveoloplasty, and frenectomy.
 - f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
 - g. Re-implantation or transplantation of a natural tooth.
 - h. General anesthesia, only when provided in conjunction with **a surgical** procedure.
7. Bacteriologic cultures in connection with a covered dental service.
8. Therapeutic injections administered by a dentist
9. Repairs and adjustments to full or partial dentures.
10. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.

11. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.
12. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture.
13. Repair or recementing of crowns, inlays, onlays or bridgework.
14. Specialists consultations and specialty examinations provided the covered person has been referred by a general dentist. These consultations and examinations are not restricted to the limitations for routine oral exams.

Major Dental Expenses

1. Post and core on permanent teeth only.
2. Plastic or stainless-steel crowns will be covered for primary teeth only and the five (5) year limitation, as noted below will not be applied.
3. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are anterior to the first bicuspid are not covered.
4. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth which are posterior to the first bicuspid are not covered.
5. Crowns: Covered only when the tooth cannot be restored by a basic restoration, and then only if at least five (5) consecutive years have lapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.
6. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth extracted.
7. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth extracted.
8. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.

9. Complete dentures for teeth extracted.

Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.
2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for a both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Orthodontic Services (for dependent children through age 19 only.)

Subject to the limitations specified on the Schedule of Benefits, covered expense shall include:

1. Any dental expense furnished in connection with the orthodontic treatment;
2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment. Includes routine x-rays, local anesthetics, and post-surgical care.
3. Active appliances, diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.

Orthodontic services are subject to a twelve (12) month waiting period after the covered person's effective date of coverage. Upon proof of twelve (12) months of previous creditable coverage, this waiting period shall be waived.

Orthodontia benefits will begin upon submission of proof that the orthodontia services have been received. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is specified on the Schedule of Benefits. This maximum applies to the entire period(s) a person is covered under the Plan.

SECTION I

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. In addition, when this Plan pays second, it will never pay more in benefits than it would have paid during the Plan Year for each claim as it is submitted had it been the Plan 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 trustee 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 person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:
1. secondary to the Plan covering the person as a dependent; and
 2. primary to the Plan covering the person as other than a dependent (that is, the Plan covering the person as a retired employee);

then the order of benefits is reversed, so that the Plan covering the person as a dependent pays first; and the Plan covering the person other than as a dependent (that is, as a retired employee) pays second.

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 an 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 J

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 cannot 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 K

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 A 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/Dentist or surgeon, and the Physician/Dentist-patient relationship shall be maintained. The Plan Member, together with his Physician/Dentist, is ultimately responsible for determining the appropriate course of dental treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO 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.

Entire Plan

The Plan including any amendments, the Schedule of Coverage, any other applicable schedules, the attached papers, 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/dental expense benefits payable under this Plan shall be paid to the medical/dental service provider, unless the claimant furnishes proof of payment of the medical/dental expenses at the time the claim is filed with the Claims Administrator, in which case the benefits shall be paid to the claimant.

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 L

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 M

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, 90 Degree Benefits, 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. 90 Degree Benefits, 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 90 Degree Benefits, 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.**

Employee Benefit Trust Board Meeting

3. B.

Meeting Date: 06/23/2021

Department Head: Maria Munoz, HR Benefits Coordinator, Human Resources Department

Submitted By: Maria Munoz, HR Benefits Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding the quarterly review of the benefit plan. **(Susan Posada, Broker and Consultant).**

SUMMARY:

The Trustees are to meet quarterly to review the Trust Fund on a quarterly basis. This would be to ensure "sufficient funds to exist to pay outstanding and future benefits, to pay for losses or claims or any combination of insurance and direct payment, and to pay for risk management consultation."

This item is informational. However, it has been put on the agenda as an action item in case there is any action the Board wishes to take.

RECOMMENDATION / SUGGESTED MOTION:

I MOTION TO _____.

Fiscal Impact

Fiscal Impact:

N/A

Employee Benefit Trust Board Meeting

3. C.

Meeting Date: 06/23/2021

Department Head: Maria Munoz, HR Benefits Coordinator, Human Resources Department

Submitted By: Maria Munoz, HR Benefits Coordinator, Human Resources Department

ITEM:

Discussion and possible action on any and all matters regarding Broker agreement renewal. **(Susan Posada, Broker and Consultant)**

SUMMARY:

Background

The 2013 broker agreement was last extended in 2019 to June 30, 2021. In that extension amendment, the agreement renews automatically for two-year periods, unless at the end of any period of extension, a party gives the other party at least 60 days' notice in writing of the intention to terminate.

At the March 10, 2021, meeting of the trust, Susan Posada offered an amendment with a simple 3-year extension (rather than the 2-year automatic extension) with no change in commission (Number 6 attachment to this Agenda Item). The Trust continued the item to the May 5, 2021, meeting. After discussion in both an open session and in an executive session, there was insufficient time for an open session vote due to a City Council Work Session scheduled at 6:30 p.m. that day.

The item is on the agenda to consider an alternate proposal to extend the agreement for 3 years to July 1, 2024, and on or before June 30, 2023, the Trust may give written notice to Ms. Posada of its intent to put out the Agreement for a request for qualifications and proposals for services to start July 1, 2024.

Attachments to this Agenda

The first attachment is the proposal to give a year's notice of intent to go out for requests for qualifications and proposals.

The second attachment is the broker history.

The third through fifth attachments are the agreement and the amendments to date.

The sixth attachment is Ms. Posada's proposed amendment for a three-year extension.

Services

The services include (but are not limited to) the following consultant and brokerage services on the following benefits for both the U.S. and Mexico Plans:

- Medical,
- Prescription Drugs,
- Dental,
- Short-term Disability/Salary Continuation,
- Long-term Disability,
- Group Life Insurance,
- Voluntary Life and Accidental Death and Disability, and
- Other related services.

In addition, the agreement provides that Ms. Posada will :

- give information on legislative developments affecting employee benefit plans,
- meet quarterly, semi-annually and annually for strategic planning for the Trust, and
- assist with the administration of the programs, including resolution of vendor service issues and

addressing employee and management questions.

Renewal Options:

Option 1 - Renew broker agreement for three years with the option of going out to bid with one-years' notice in 2023.

Option 2 - Renew broker agreement for a flat three years.

Option 3 - Renew automatically for two years with both parties having the option of 60-days' notice to end renewal at the end of the two years under the current amendment signed June 12, 2019.

RECOMMENDATION / SUGGESTED MOTION:

I MOVE TO APPROVE OPTION ____ AS PRESENTED.

Fiscal Impact

Fiscal Impact:

The Broker/Consultant Commission shall not exceed 5% of the fully insured equivalent as determined by EBSO or the appointed Third-Party Administrator (TPA) each year. This amount is calculated by the TPA and provided as a Per Employee Per Month (PEPM) format.

The fee for the duration will not exceed \$35.00 PEPM.

Attachments

2021 - 2024 Broker Amendment

Commission history up to 2019

2013 Broker Agreement

2018 Broker Amendment

2019 Broker Amendment

2021-03-10 Broker's Proposed Agreement

AMENDMENT TO BROKER/CONSULTANT AGREEMENT DATED MAY 22, 2013

The San Luis Employee Benefit Trust, hereinafter referred to as “Client” and Susan Posada Agency, Inc., hereinafter referred to as “Broker/Consultant,” and in consideration of the mutual covenants contained herein, agree as follows:

1. The Client is the successor to the Broker/Consultant agreement between the City of San Luis and Susan Posada Agency dated May 22, 2013 (hereinafter referred to as the “Agreement”). The Client extended the Agreement to July 1, 2021, in the amendment dated June 12, 2019. Under the terms of said 2019 amendment, the Agreement renews automatically for two-year periods, unless at the end of any period of extension, a party gives the other party at least 60 days’ notice in writing of the intention to terminate. For the Client’s March 10, 2021, meeting, the Broker proposed a 3-year renewal. The item was continued to the May 5, 2021, meeting and was discussed in executive session. An open session vote was not possible because the executive session ran up to the City Council Work Session time.

2. All provisions of the Agreement, as previously amended, unless amended by the terms of this amendment shall remain unchanged and in full force and effect.

3. Paragraph number three (3) of the amendment dated June 12, 2019, is hereby amended as follows:

a. The parties hereto agree to extend the Agreement to July 1, 2024.

b. On or before June 30, 2023, the Client may give written notice to Broker of its intent to put out the Agreement for a request for qualifications and proposals or take such other action in its fiduciary responsibility. The selected broker firm will commence creating a benefits plan for the July 1, 2024, through June 30, 2025, fiscal year on October 1, 2023. If the selected broker firm is not the current Broker, then as a transition, the current Broker shall continue all aspects of this Agreement, including working with the selected broker in creating a benefits plan to the extent that proprietary property is protected and not infringed. The Client will compensate the current Broker through June 30, 2024, according to sections 4 and 5 below.

4. For the period of July 1, 2021, through June 30, 2024, the Broker/Consultant commission shall not exceed 5% of the fully insured equivalent as determined by the Third-Party Administrator (“TPA”) each year. This amount is calculated by the TPA and provided as a Per Employee Per Month (“PEPM”) format. The commission for the duration of the term of the Agreement will not exceed \$35 PEPM unless changed by written amendment executed by the parties hereto.

5. Any other ancillary fees as paid by the carrier are standard fees paid by the carrier, such as for coverage for vision, disability, and life coverage. Such payment shall be paid directly by such carrier and not by the Client.
6. This amendment may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The signature pages from one or more counterparts may be removed from such counterparts, and such signature pages all attached to a single instrument so that the signature of all parties may be physically attached to a single document.
7. Time is of the essence of the Agreement as amended.
8. It is not intended by this amendment to the Agreement to, and nothing contained in the Agreement as amended shall create any partnership, joint venture or other similar arrangements between Client and Broker/Consultant. No term or provision of this Agreement as amended is intended to, or shall, be for the benefit of any person, firm, organization or corporation, not a party hereto, and no such other person, firm, organization or corporation shall have any right or cause of action hereunder.
9. This amendment to the Agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof. All prior and contemporaneous agreements, representations and understandings of the parties, oral or written, are hereby superseded and merged herein.
10. No change or additions are to be made to the Agreement as amended except by a written amendment executed by the parties hereto.
11. This amendment to the Agreement is entered into in Arizona and shall be construed and interpreted under the laws of the State of Arizona. In particular, the Agreement as amended is subject to the provisions of A.R.S. § 38-511.
12. Any legal action relating to the Agreement as amended shall be brought in either the Yuma County Superior Court or in the United States District Court for the District of Arizona at the election of the plaintiff in such legal action, provided, however, that nothing in this paragraph will be deemed to have authorized the bringing of any legal action in a court which does not otherwise have jurisdiction to adjudicate the legal action.
13. Every provision of this Agreement as amended is, and will be construed to be, a separate and independent covenant. If any provision of the Agreement as amended or the application of the same is, to any extent, found to be invalid or unenforceable, then the remainder of the Agreement as amended or the application of that provision to circumstances other than those to which it is invalid or unenforceable, will not be affected by that invalidity or unenforceability, and each provision of this Agreement as amended will be valid and will be enforced to the extent permitted by the law, and the parties will negotiate in good faith for such amendments of this Agreement which may be necessary to achieve its intent, notwithstanding such invalidity or unenforceability.

The parties have executed this amendment to the Agreement.

Susan Posada Agency Inc.

San Luis Employee Benefit Trust

Susan Posada, President & Owner

Gerardo Sanchez, Chair

Date: _____

Date: _____

APPROVED AS TO FORM:

Kay Marion Macuil
City Attorney-Attorney for
San Luis Employee Benefit Trust

Commissions History								City of San Lus							
For Susan Posada as of March 12, 2019															
	2013-2014		2014-2015		2015-2016		2016-2017		2017-2018		2018-2019		2019-2020		
Commission PEPM	\$34.07		\$30.00		\$32.00		\$33.50		\$33.50		\$35		\$35		
Percentage of Premium	5.00%		\$3.0%		2.70%		3.10%		3.00%		3.10%		3.1% Est.		

Commissions are calculated by EBSO and determined based on the fully insured equivalent

Broker/Consultant Agreement

This Broker Agreement, hereinafter referred to as "Agreement" is between **City of San Luis**, hereinafter referred to as "Client" and **Susan Posada Agency Inc.**, hereinafter referred to as "Broker/Consultant."

WHEREAS, Client wishes to obtain the assistance of Consultant with strategic benefit planning, design, funding, administration, and communication with respect to its employee benefit programs;

WHEREAS, Consultant has knowledge and expertise in assisting employers with designing and servicing employee benefit plans; and

WHEREAS, the parties wish to set forth their respective expectations;

Now, therefore, for good and valuable consideration, the receipt and sufficiency of which is hereby mutually acknowledged, the parties hereby agree as follows:

I. Scope of Services to be Provided by Consultant

Consultant will provide Client with consulting, and brokerage services for the following compensation and benefit programs listed below:

- Medical (including retirees)
- Prescription Drugs
- Dental
- Vision
- Short-term Disability/Salary Continuation
- Long-term Disability
- Group Life Insurance
- Voluntary Life and AD&D
- Other Related Services

1. Purpose:

Our Purpose is to provide the following general services, but not limited to the following:

- a. To review, advise and make recommendations on the appropriate types of insurance coverage's.
- b. Market, manage and coordinate the bidding process for proposals as required and make recommendations on various carriers and plan designs, stop loss carriers and other related vendors.
- c. Act as a liaison and advocate for the City with the selected insurance companies.
- d. Develop new alternatives to traditional insurance plans as appropriate for the City.
- e. Develop and produce communication material including a custom benefit website.

2. Approach:

Annual Renewal Process

The approach in performing the scope of work is detailed as follows:

- a. As the assigned consultant, a review of the employee benefits, contracts, certificates of coverage and premiums will be performed. An analysis of the insurance proposal will be done and findings will be presented to management. Consult with the Human

- Resources Manager or designee to understand the City's goals, objectives, and proposed changes to plan designs. Listen to concerns and challenges with present carriers. Obtain the needed information to properly design and prepare bid specifications, including but not limited to census information, premium history and carrier statistics (e.g. claims experience, network utilization, RX utilization, premium and loss ratio reports).
- b. Consult with the City on alternative methods to reduce premium dollars and maximize benefit plan designs based on market conditions.
 - c. Prepare bid specifications and review with Human Resources Manager or designee. The bid specifications are designed based on the City's goals, objectives, employees' input, cost and knowledge of the market place.
 - d. Distribute bid request to carriers based on their ability to provide service, history of service, claims experience and general market conditions.
 - e. Analyze bids received. The bids are reviewed for accuracy, ability to perform services in geographic and specific specialty areas. The bids are compared to ensure that the highest benefit is received for the least premium dollar while maintaining the quality of service.
 - f. Negotiate premiums and benefits with the carriers where appropriate.
 - g. Written and verbal recommendations are made to the Human Resources Manager or designee and to the City Council and others as required by the City of San Luis. Once the bid is accepted, a review for any changes is made with the Human Resources Manager or designee.
 - h. Review each carrier's summaries, certificate of coverage, contracts and other printed material to ensure accuracy and adherence to agreements. Coordinate with carrier's and order orientation material and prepare necessary documents required by the carrier to hold enrollment meetings as required by the City of San Luis.
 - i. Manage and Coordinate Open Enrollment Meetings and coordinate with various carriers and the City staff for a successful enrollment.
 - j. Develop and produce benefit material for Open Enrollment meetings and preparation of website for use by Human Resources and employees.

3. Work Plan: Approach, Annual Renewal and Reviews

Approach:

The approach in performing the scope of work is detailed as follows:

Bidding/Renewal Process Continued:

- a. Follow up with carriers to ensure timely receipt of enrollment cards and material.
- b. Review with Human Resource Manager monthly and/or Quarterly carrier status (e.g. claim experience, network utilization, Rx utilization premium and loss ratios) and make modification recommendations, work with carrier or third party administrator to reduce cost.

4. Work Plan: Approach, Ongoing Communication and Meetings

Our objective is to assist, support and educate employees and management with all of the selected benefits. To continually monitor all plans to ensure employee and management satisfaction. The following is our approach:

- a. Coordinate with carrier (s) and prepare necessary documents required by the carrier and hold enrollment meetings as required by the City.

- b. Assist in the enrollment process and obtain new enrollment information for all employees. Work with Human Resources to ensure accuracy of those enrolled with each carrier.
- c. Prepare a brochure that includes cost, summary of benefits, carrier contact and general employee benefit information, to be provided along with all enrollment material to employees.
- d. Prepare and update a custom benefit website with carrier and other required information for the employees and Human Resources.
- e. Follow up to ensure accuracy and timely receipt of member ID cards, summaries, certificates of coverage and claim forms.
- f. Review and present copies of contracts, applications of all benefits to Human Resource Manager in a form that is easily accessible.
- g. Act as consultant on an ongoing basis on various employee benefit related issues; assist in claim and billing management. Interact with City as changes may develop in the employee benefits area that impact the City and its employees.
- h. To review and analyze claim reports, monthly or quarterly as deemed necessary and review with the Human Resource Manager or designee, Management and City Council as needed.
- i. Assist the City in any written procedures and proposals as needed. Communicate and assist in coordinating meetings, answering questions and communicating changes as needed.
- j. Consultant will advise and counsel regarding program funding alternatives, including review fee proposals, recommend budget rates, employee contribution rates, and COBRA rates; select and procure appropriate stop loss terms; and monitor program costs against expectations.
- k. Communication - assist in drafting employee communications regarding benefit program performance and changes, and assist in the review of plan documents and insurance certificates during the planning and enrollment process.

5. Other Services

- A. **Compliance Tools & Legislative Information.** Consultant will provide informational materials on legislative developments affecting employee benefit plans, including access to online reference tools on topics such as FMLA, COBRA, HIPAA, HIPAA Privacy, and Section 125.
- B. **Meetings with Client and Vendors.** Services will include attendance at and facilitation of regular meetings with Client and vendors as needed to facilitate program management including day-to-day operations and planning program changes.
 - Consultant shall meet with Client on a quarterly basis to review all activities performed by Consultant during the prior quarter. The meetings will include discussion of business concerns, including presentations of options and recommendations.
 - Consultant shall meet with Client semi-annually to discuss review of the program, state of the marketplace, progress made toward strategic plan, and developments within Client's organization.
 - Consultant shall meet with Client annually to review the claims reports and review plan performance for the preceding year, review goals and objectives for the upcoming year, and agree upon Consultant's fees for the next twelve-month period.

- C. **Day-to-Day Administrative Issues.** Consultant shall provide assistance in the daily administration of programs, including resolution of vendor service issues and addressing questions and concerns raised by Client's employees and management.

II. Disclosure and Recordkeeping

1. **Full Disclosure.** Client shall approve any arrangements and/or the utilization of any intermediaries in connection with, or arising out of, or in any way related to Client's insurance and risk management program. Consultant must seek approval from Client prior to the use of any of the above in connection with the Client's insurance and risk management program.
2. **Recordkeeping.** Consultant will maintain accurate and current files including, but not limited to, insurance policies and correspondence with insurers or brokers in accordance with industry standard record retention practice or as otherwise directed by Client.

III. Term & Termination

1. **Term.** This initial term of this Agreement shall be 3 years, commencing on April 1, 2013 and ending July 1, 2016 ("Initial Term"). Thereafter, this Agreement will remain in effect until terminated as described below.
2. **Termination.** This Agreement may be terminated by either party only as follows:
 - Effective upon thirty (30) days advance written notice to the other party stating that such other party is in breach of any of the provisions or non-performance of this Agreement, provided such breach (if able to be cured) is not cured within fifteen (15) days after the notice is received;
 - The city can elect to extend or continue this contract beyond the 3 years.

IV. Cost of Services

Consultant professional fees are based upon time expended by specific individuals. The fees do not include out-of-pocket expenses, including expenses related to travel outside of the state. Client agrees to pay Consultant professional fees as outlined in Exhibit 1. These annual fees are payable in monthly installments and Consultant agrees to submit invoices to Client on a monthly basis.

Invoices are prepared and sent by the Third Party Administrator (TPA) according to the agreement and provided monthly by the TPA. Payment for the consultant professional fees, calculated by the TPA are paid by the TPA on a monthly basis.

Additional programs and services will be provided on a project basis for an additional fee to be disclosed in writing and shall be undertaken upon mutual agreement between Consultant and Client. Such programs and services may include, but not be limited to, retiree medical plans, special employee surveys, employee communication materials, and long-term care insurance, vision, disability, life, supplemental life and any other required by the Client. Such Ancillary benefits are paid by the carrier and not by the Client.

V. Personnel

Consultant will assign its personnel according to the needs of Client and according to the disciplines required to complete the appointed task in a professional manner. Consultant retains the right to substitute personnel with reasonable cause. The Account Management Team consists of the following individuals:

Primary Service Team: Susan Posada
Broker/Consultant/ Account Manager

Other Personnel shall be assigned as designed for quality services

VI. Client's Responsibilities

Client will make available such reasonable information as required for Consultant to conduct its services. Such data will be made available as promptly as possible. It is understood by Consultant that the time of Client's personnel is limited, and judicious use of that time is a requirement of this Agreement. Client will make timely payments of the service fees as set forth elsewhere in this Agreement.

VII. Records and Information

Consultant understands and agrees to limit its use and disclosure of protected health information as described in Exhibit 2.

VIII. Independent Contractor

It is understood and agreed that Consultant is engaged by Client to perform services under this Agreement as an independent contractor. Consultant shall use its best efforts to follow written, oral, or electronically transmitted (i.e., sent via facsimile or e-mail) instructions from Client as to policy and procedure.

IX. Fiduciary Responsibility.

Client acknowledges that: (i) Consultant shall have no discretionary authority or discretionary control respecting the management of any of the employee benefit plans; (ii) Consultant shall exercise no authority or control with respect to management or disposition of the assets of Client's employee benefit plans; and (iii) Consultant shall perform services pursuant to this Agreement in a non-fiduciary capacity. Client agrees to notify Consultant as soon as possible of any proposed amendments to the plans' legal documents to the extent that the amendments would affect Consultant in the performance of its obligations under this Agreement. Client agrees to submit (or cause its agent, consultants, or vendors to submit) all information in its (or their) control reasonably necessary for Consultant to perform the services covered by this Agreement.

X. Entire Agreement

This constitutes the entire Agreement between the parties, and any other warranties or agreements are hereby superseded.

Subsequent amendments to this Agreement shall only be in writing signed by both parties.

Raene New
Signature
City Manager
Title

6/05/2013
Date

Susan Posada Agency Inc.
[Signature]
Signature
President
Title

6/24/13
Date

Exhibit 1

Consulting Fees

The Broker/Consultant commissions shall not exceed 5% of the fully insured equivalent as determined by MMSI/Mayo or the appointed Third Party Administrator each year. This amount is calculated by the third party administrator and provided as a Per Employee Per Month (PEPM) format.

For the year beginning July 1, 2012 to July 1, 2013 the fee as determined by the TPA was \$33.00 and the Consultant agreed to a \$30.00 PEPM. The rate calculation for the \$33.00 fee is attached.

For the year beginning July 1, 2013, the rate as determined by MMSI/Mayo is \$34.07. For the plan year the Broker Consultant has elected to receive \$32 Per Employee Per Month instead of the \$34.07. The rate will not exceed the 5% as determined each year for Medical and Dental benefits as administered by MMSI/Mayo. The calculation by MMSI/Mayo for Plan year 2013/2014 is attached to this contract.

Each plan year beginning 7/1/13 the fee will be calculated based on th 5% of the fully insured equivalent as determined by the TPA.

Any other ancillary fees as paid by the carrier are standard fees paid by the carrier such as for coverage for vision, disability and life. Such payment is paid directly by each carrier and not by the Trust through MMSI/Mayo.

Mayo Clinic Health Solutions
Estimated Premium Rate Comparison for
City of San Luis
based on Reinsurer Expected Claims Liability

Current Premium - 2012/2013 Plan Year

- Dependent rates include Employee cost

Coverage	Enrollment Tier	Enrollment Count	Fully Ins'd Equiv Rate	Monthly Premium
Medical	US & Mexico - Employee Cost	89	\$ 429.00	\$ 38,181.00
Medical	US & Mexico - <u>Emp</u> & Spouse Cost	7	\$ 890.24	\$ 6,231.68
Medical	US & Mexico - <u>Emp</u> & Child(ren) Cost	40	\$ 890.24	\$ 35,609.60
Medical	US & Mexico - <u>Emp</u> , Spouse & Child(ren) Cost	17	\$ 1,361.84	\$ 23,151.28
Med & Dent	Mexico - Emp, Spouse & Child(ren) Cost	44	\$ 358.20	\$ 15,760.80
Dental	US & Mexico - Employee Cost	87	\$ 30.00	\$ 2,610.00
Dental	US & Mexico - <u>Emp</u> & Spouse Cost	6	\$ 67.86	\$ 407.16
Dental	US & Mexico - <u>Emp</u> & Child(ren) Cost	27	\$ 67.86	\$ 1,832.22
Dental	US & Mexico - <u>Emp</u> , Spouse & Child(ren) Cost	35	\$ 67.86	\$ 2,375.10
Dental Only	US & Mexico - Dependent Cost	0	\$ 37.86	\$ -
Monthly Premium -				<u>\$ 126,158.84</u>
Annual Premium -				<u>\$ 1,513,906.08</u>

Required Premium based on Rates and Factors - 2013/2014 Plan Year

Fixed Rates

Specific Premium - Employee (\$50K)	89	\$ 92.48	\$ 8,230.72
Specific Premium - Family (\$50K)	64	\$ 228.97	\$ 14,654.08
Aggregate Premium	197	\$ 4.24	\$ 835.28
Medical/Rx Claims Administration Fee	197	\$ 16.70	\$ 3,289.90
Dental Claims Administration Fee	196	\$ 2.60	\$ 509.60
Broker Fee	197	\$ 33.00	\$ 6,501.00
Utilization Review/Case Management Fee	197	\$ 3.00	\$ 591.00
COBRA/HIPAA Fee	197	\$ 0.79	\$ 155.63
PPO Fee - BCBSAZ Medical	153	\$ 13.50	\$ 2,065.50
PPO Fee - BCBSAZ Dental	153	\$ 1.50	\$ 229.50
PPO Fee - Siamed	197	\$ 4.00	\$ 788.00

Aggregate Factors - Medical & Rx

Employee	89	\$ 251.54	\$ 22,387.42
Family	108	\$ 625.09	\$ 67,509.50

Estimated Dental Claims

	\$ 6,500.00
Monthly Premium -	<u>\$ 134,247.13</u>
Annual Premium -	<u>\$ 1,610,965.56</u>

Proposed Premium - 2013/2014 Plan Year

- Dependent rates include Employee cost

Coverage	Enrollment Tier	Enrollment Count	Fully Ins'd Equiv Rate	Monthly Premium
Medical	US & Mexico - Employee Cost	89	\$ 456.50	\$ 40,628.50
Medical	US & Mexico - <u>Emp</u> & Spouse Cost	7	\$ 947.32	\$ 6,631.24
Medical	US & Mexico - <u>Emp</u> & Child(ren) Cost	40	\$ 947.32	\$ 37,892.80
Medical	US & Mexico - <u>Emp</u> , Spouse & Child(ren) Cost	17	\$ 1,449.15	\$ 24,635.55
Med & Dent	Mexico - Emp, Spouse & Child(ren) Cost	44	\$ 381.16	\$ 16,771.04
Dental	US & Mexico - Employee Cost	87	\$ 31.92	\$ 2,777.04
Dental	US & Mexico - <u>Emp</u> & Spouse Cost	6	\$ 72.21	\$ 433.26
Dental	US & Mexico - <u>Emp</u> & Child(ren) Cost	27	\$ 72.21	\$ 1,949.67
Dental	US & Mexico - <u>Emp</u> , Spouse & Child(ren) Cost	35	\$ 72.21	\$ 2,527.35
Dental Only	US & Mexico - Dependent Cost	0	\$ 40.29	\$ -
Monthly Premium -				<u>\$ 134,246.45</u>
Annual Premium -				<u>\$ 1,610,957.40</u>

Commissions based on Expected Liability:

Commission Percent	5%
Annual Commission	\$ 80,547.87
Monthly Commission	\$ 6,712.32
PEPM Commission	\$ 34.07

Exhibit 2
Business Associate Contract

This Business Associate Contract (Agreement) is entered into by and between the **City of San Luis**, and **Susan Posada Agency Inc.**, (Business Associate) effective as of July 1, 2013.

WHEREAS, the Covered Entity is a group health plan as defined in the privacy rules adopted pursuant to the Health Insurance Portability and Accountability Act of 1996¹ (HIPAA);

WHEREAS, the Business Associate wishes to perform on behalf of the Covered Entity treatment, payment, or health care operations as defined by HIPAA;

WHEREAS, the parties wish to set forth their understandings with regard to the use and disclosure of Protected Health Information (PHI) by the Business Associate in performance of its obligations;

In consideration of the mutual promises set forth below, the parties hereby agree as follows:

A. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

1. Use of Protected Health Information (PHI). Business Associate shall not use or further disclose PHI other than as permitted or required by this Agreement or as required by law. To the extent practicable, Business Associate shall limit its use or disclosure of PHI or requests for PHI to a limited data set, or if necessary, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request.
2. Safeguards. Business Associate shall use appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement, including establishing procedures that limit access to PHI within its organization to those employees with a need to know the information. Business Associate agrees that it will implement appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Covered Entity, as required by the HIPAA Security Rules.

Business Associate acknowledges that the requirements of 45 C.F.R. Sections 164.308, 164.310 and 164.312 applicable to such administrative, physical and technical safeguards apply to Business Associate in the same manner that such sections apply to Covered Entity. Further, Business Associate shall implement, and maintain in written form, reasonable and appropriate policies and procedures to comply with the standards, implementation specifications or other requirements of the HIPAA Security Rule, in accordance with 45 C.F.R. Section 164.316, which applies to Business Associate in the same manner that such sections apply to Covered Entity.
3. Unauthorized Disclosures of PHI. Business Associate shall, within ten (10) business days of becoming aware of a disclosure of PHI in violation of this Agreement by Business Associate, its officers, directors, employees, contractors, or agents or by a third party to which Business Associate disclosed PHI (including a subcontractor), report to Covered Entity any such disclosure. Business Associate agrees to mitigate, to the extent practicable, any harmful effect of the unauthorized disclosure or misuse of PHI.
4. Security Incidents. Business Associate shall promptly report to Covered Entity any Security Incident of which it becomes aware, in accordance with the HIPAA Security Rule.
5. Agreements With Third Parties. Business Associate agrees to ensure that any agents and subcontractors that create, receive, maintain or transmit PHI on behalf of Business Associate with

respect to Business Associate's relationship with Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information.

6. Access to Information. Within ten (10) days of a request by the Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to the Covered Entity such PHI for so long as such information is maintained in a Designated Record Set and in accordance with the requirements of 45 C.F.R. Section 164.524. In the event any individual requests access to PHI directly from the Business Associate, Business Associate shall respond to the request for PHI within ten (10) days. Any denials of access to the PHI requested shall be the responsibility of the Business Associate.
7. Availability of PHI for Amendment. Business Associate agrees to make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR Section 164.526 at the request of the Covered Entity or an individual, and in the time and manner designated by Covered Entity.
8. Inspection of Books and Records. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary of the U.S. Department of Health and Human Services or its designee (the "Secretary"), in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with HIPAA.
9. Accounting of Disclosures. Business Associate agrees to maintain and make available to the Covered Entity an accounting of disclosures of PHI as would be required for Covered Entity to respond to a request by an individual made in accordance with 45 CFR Section 164.528. Business Associate shall provide an accounting of disclosures made during the six (6) years prior to the date on which the accounting is requested (or during the three (3) years prior to the date the accounting is requested for PHI maintained in an electronic health record, beginning on the applicable effective date pursuant to the American Recovery and Reinvestment Act of 2009). At a minimum, the accounting of disclosures shall include the following information:
 - a. Date of disclosure,
 - b. The name of the person or entity who received the PHI, and if known, the address of such entity or person,
 - c. A brief description of the PHI disclosed, and
 - d. A brief statement of the purpose of such disclosure, which includes an explanation of the basis of such disclosure.

In the event the request for an accounting is delivered directly to the Business Associate, the Business Associate shall respond to the request within ten (10) days. Any denials of a request for an accounting shall be the responsibility of the Business Associate.

Business Associate agrees to implement an appropriate record keeping process to enable it to comply with the requirements of this Section.

10. Remuneration in Exchange for PHI. Effective Sept. 23, 2013, the effective date of the final HIPAA regulations pursuant to the American Recovery and Reinvestment Act of 2009 and subject to the transition provision of 45 CFR Section 164.532 regarding prior data use agreements, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI without a valid authorization permitting such remuneration, except as permitted by law.

B. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

1. Business Associate shall not use or disclose any PHI for any purpose other than performance of services for Covered Entity as provided for in the Consulting Agreement dated July 1, 2013. Except as otherwise limited by this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified above, provided that such use or disclosure would not violate HIPAA if done by the Covered Entity.

C. OBLIGATIONS OF COVERED ENTITY

1. Covered Entity shall comply with each applicable requirement of the HIPAA Privacy and Security Rules
2. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR Section 164.520, as well as any changes to such notice.
3. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.
4. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR Section 164.522.

D. PERMISSIBLE REQUESTS BY COVERED ENTITY

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if done by the Covered Entity.

E. TERMINATION

1. Term. The term of this Agreement shall begin on the Effective Date and shall remain in effect until terminated under Section E(2) of this Agreement.
2. Termination. This Agreement shall be terminated only as follows:
 - a. Termination For Cause by Covered Entity

This Agreement may be terminated by the Covered Entity upon fifteen (15) days written notice to the Business Associate in the event that the Business Associate breaches any provision contained in Paragraphs A or B of this Agreement and such breach is not cured within such fifteen (15) day period.
 - b. Termination for Cause by Business Associate

Effective February 17, 2010, this Agreement may be terminated by the Business Associate upon fifteen (15) days written notice to the Covered Entity in the event that the Covered Entity breaches any provision contained in Paragraphs C or D of this Agreement and such breach is not cured within such fifteen (15) day period.
 - c. Termination Due To Change in Law

Either party may terminate this Agreement effective upon thirty (30) days advance written notice to the other party in the event that the terminating party has sought amendment of this Agreement pursuant to Paragraph G(1) and no amendment has been agreed upon.
 - d. Termination Without Cause

Either may terminate this Agreement effective upon ninety (90) days advance written notice to the other party given with or without any reason.

3. Return or Destruction of PHI

Upon termination of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created maintained or received by Business Associate on behalf of Covered Entity that the Business Associate maintains in any form. Business Associate shall retain no copies of the PHI.

Notwithstanding the above, to the extent that it is not feasible to return or destroy such PHI, the terms and provisions of Sections A, B and C shall survive termination of this Agreement and such PHI shall be used or disclosed solely for such purpose or purposes that prevented the return or destruction of such PHI. When the PHI is no longer needed by the Business Associate, the Business associate shall return the PHI to Covered Entity or shall destroy it

F. DEFINITIONS

Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the HIPAA Privacy, Security, Breach Notification and Enforcement Rules at 45 CFR Part 160 and 164.

G. GENERAL PROVISIONS

1. Amendment. This Agreement may be amended only by the mutual written agreement of the parties. The parties agree to take such action to amend this Agreement from time to time as is necessary for the Covered Entity or Business Associate to comply with the requirements of HIPAA.
2. Indemnification. Each party shall release, indemnify and hold the other harmless from and against any claims, fees, and costs, including, without limitation, reasonable attorneys' fees and costs, which may be incurred by the acts of that party as a result of or related to the other party's activities pursuant to this Agreement.
3. Remedies. The parties acknowledge that breach of Paragraphs A or B of this Agreement may cause irreparable harm for which there is no adequate remedy at law. In the event of a breach, or if either party has actual notice of an intended breach, such party shall be entitled to a remedy of specific performance and/or injunction enjoining the other party from violating or further violating this Agreement. The parties agree the election of the party to seek injunctive relief and or specific performance of this Agreement does not foreclose or have any effect on any right such party may have to recover damages.
4. Survival. Business Associate's obligation to limit its use and disclosure of Protection Information as set out in Paragraphs A and B survive the termination of this Agreement so long as Business Associate has PHI received during the performance of its services as described in this Agreement.
5. Governing Law. This Agreement shall be construed and enforced in accordance with the laws of the State of Arizona.
6. Assigns. Neither this Agreement nor any of the rights, benefits, duties, or obligations provided herein may be assigned by any party to this Agreement without the prior written consent of the other party.
7. Third-party Beneficiaries. Nothing in this Agreement shall be deemed to create any rights or remedies in any third party.
8. Interpretation. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits the Covered Entity and/or Business Associate, as applicable, to comply with HIPAA.

9. Notices. Any notice given under this Agreement must be in writing and delivered via first class mail, via reputable overnight courier service, or in person to the following addresses, or to such addresses or facsimile numbers as the parties may specify by like notice:

If to Covered Entity:

If to Business Associate:

Susan Posada

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

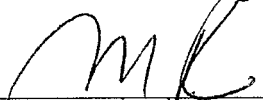
Susan Posada Agency Inc.

Signed: _____

Date: _____

Name (Print): _____

Title: _____

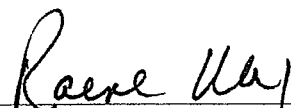

6/24/2013
Susan POSADA
owner / pres

Signed: _____

Date: _____

Name (Print): _____

Title: _____


6-05-2013
Raene Kay
CITR Mgr

Amendment to Broker/Consultant Agreement dated May 22, 2013, Exhibit 1, page 7

The three year agreement is hereby extended to July 1, 2019. The Broker/Consultant Commission shall not exceed 5% of the fully insured equivalent as determined by MMSI/Mayo or the appointed Third Party Administrator (TPA) each year. This amount is calculated by the TPA and provided as a Per Employee Per Month (PEPM) format.

Each plan year beginning July 1, 2013 the fee is calculated based on 5% of the fully insured equivalent. Beginning July 1, 2013 the rate was determined to be \$34.07 and the Broker agreed to a reduced fee of \$30.00 PEPM. The fee was later increased to \$32.00 (PEPM). The rate will not exceed the 5% as determined each year for Medical and Dental Benefits as administered by the TPA as the fully insured equivalent rate per month.

Effective July 1, 2016 the fee will change to \$33.50 Per Employee Per Month. Based on the 2015/2016 Plan Year the present rates the percentage for \$32.00 is 3.4% PEPM and \$33.50 is 3.5%. This fee shall not be less than 3% of the Fully Insured Equivalent Rate for July 1, 2016 Plan Year and beyond with mutual consent.

Any other ancillary fees as paid by the carrier are standard fees paid by the carrier such as for coverage for vision, disability and life. Such payment is paid directly by each carrier and not by the Trust through MMSI/Mayo.

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

Susan Posada Agency Inc.

Signed: _____

Date: _____

Name (Print): _____

Title: _____

Signed: _____

Date: _____

Name (Print): _____

Title: _____

Susan Posada

Broker

AMENDMENT TO BROKER/CONSULTANT AGREEMENT DATED MAY 22, 2013

Comes now the San Luis Employee Benefit Trust, hereinafter referred to as "Client" and Susan Posada Agency, Inc., hereinafter referred to as "Broker/Consultant", and in consideration of the mutual covenants contained herein, hereby agree as follows:

1. Client is the successor to the Broker/Consultant agreement between the City of San Luis and Susan Posada Agency dated May 22, 2013 (hereinafter referred to as the "Agreement"). Said Agreement has been extended twice by previous amendment. Said Agreement is scheduled to expire on July 1, 2019.

2. All provisions of the Agreement, as previously amended, unless amended by the terms of this amendment shall remain unchanged and in full force and effect.

3. The parties hereto agree to extend the Agreement for a two year period ending on July 1, 2021. Renewal thereafter for two year periods shall be automatic, provided that either party to this Agreement may terminate it at the end of any period of extension by giving the other party 60 or more days' notice in writing of the intention to terminate.

4. For the period of July 1, 2019 to June 30, 2020 the agreed commission is a rate of \$35.00 per employee per month ("PEPM"), with no change from 2018/2019. This rate shall remain in effect during the term of this Agreement unless changed by written amendment executed by the parties hereto.

5. Any other ancillary fees as paid by the carrier are standard fees paid by the carrier such as for coverage for vision, disability, and life coverage. Such payment shall be paid directly by such carrier and not by the Client.

6. This agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The signature pages from one or more counterparts may be removed from such counterparts and such signature pages all attached to a single instrument so that the signature of all parties may be physically attached to a single document.

7. Time is of the essence of this contract.

8. It is not intended by this agreement to, and nothing contained in this agreement shall, create any partnership, joint venture or other similar arrangement between Client and Broker/Consultant. No term or provision of this agreement is intended to, or shall, be for the benefit of any person, firm, organization or corporation not a party hereto, and no such other person, firm, organization or corporation shall have any right or cause of action hereunder.

9 This agreement constitutes the entire agreement between the parties hereto pertaining to the subject matter hereof. All prior and contemporaneous agreements,

representations and understandings of the parties, oral or written, are hereby superseded and merged herein.

10. No change or additions are to be made to this agreement except by a written amendment executed by the parties hereto.

11 This agreement is entered into in Arizona and shall be construed and interpreted under the laws of the State of Arizona. In particular, this agreement is subject to the provisions of A.R.S. § 38-511.

12. Any legal action relating to this agreement shall be brought in either the Yuma County Superior Court or in the United States District Court for the District of Arizona at the election of the plaintiff in such legal action, provided, however, that nothing in this paragraph will be deemed to have authorized the bringing of any legal action in a court which does not otherwise have jurisdiction to adjudicate the legal action.

13. Every provision of this agreement is, and will be construed to be, a separate and independent covenant. If any provision of this agreement or the application of the same is, to any extent, found to be invalid or unenforceable, then the remainder of this agreement or the application of that provision to circumstances other than those to which it is invalid or unenforceable, will not be affected by that invalidity or unenforceability, and each provision of this agreement will be valid and will be enforced to the extent permitted by the law, and the parties will negotiate in good faith for such amendments of this agreement which may be necessary to achieve its intent, notwithstanding such invalidity or unenforceability.

14. Broker/Consultant hereby represents that it does not boycott Israel.

The parties have executed this agreement on the 12th day of June, 2019.

Susan Posada Agency, Inc.

San Luis Employee Benefit Trust

By: 

By: 

Approved as to form:

Kay Marion Maciel
City Attorney – Attorney for San Luis
Employee Benefit Trust

Amendment to Broker/Consultant Agreement dated May 22, 2013, 2019, Exhibit 1, page 7

The three-year agreement is hereby extended to July 1, 2024. The Broker/Consultant Commission shall not exceed 5% of the fully insured equivalent as determined by EBSO or the appointed Third-Party Administrator (TPA) each year. This amount is calculated by the TPA and provided as a Per Employee Per Month (PEPM) format.

The fee for the duration will not exceed \$35 PEPM.

Any other ancillary fees as paid by the carrier are standard fees paid by the carrier such as for coverage for vision, disability and life. Such payment is paid directly by each carrier and not by the Trust.

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

Susan Posada Agency Inc.

City of San Luis

Signed: _____

Signed: _____

Date: _____

Date: _____

Name (Print): _____

Name (Print): _____

Title: _____

Title: _____