MEDICAL AND PRESCRIPTION DRUG PLAN

MASTER PLAN DOCUMENT

CITY OF AUBURN

EFFECTIVE DATE OF THE ORIGINAL PLAN: JULY 1, 2003
EFFECTIVE DATE OF THE FIRST RESTATED PLAN: JANUARY 1, 2009

CITY OF AUBURN

MASTER PLAN DOCUMENT FOR SELF-FUNDED GROUP MEDICAL AND PRESCRIPTION DRUG BENEFITS

To be effective January 1, 2009, City of Auburn adopts this Restated Master Plan Document which includes Group Medical and Prescription Drug Benefits.

City of Auburn adopts and accepts this Restated Master Plan Document.

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Date

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Signature

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Print or Type Name

_____
Witness Name

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MANAGED CARE

Pre-admission Review

Non-urgent Care Admission

Pre-admission reviews the request for a hospital admission and the number of days for the hospital stay to determine whether the admission and the number of days for the hospital stay are within the guidelines of the Plan. All non-urgent care hospital admissions must be pre-certified before a hospital admission by calling the Individualized Care Management (ICM) Managed Care Department at their toll-free number.

Urgent Care Admission

An *"Urgent Care"* admission is one where application of the time period for making non-urgent care determinations could either:

1. *Seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or*
2. *In the opinion of a physician with knowledge of the medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care which is the subject of the claim.*

If a covered person is admitted to the hospital for an "Urgent Care" admission, as defined above, then no pre-certification is required for that admission. However, the ICM Managed Care Department must be notified within the first business day following the "Urgent Care" admission by calling its toll-free number.

Questions regarding decisions made by Utilization Review may be directed to the ICM Managed Care Department by calling its toll-free number.

Mothers and Newborns

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). Maternity stays exceeding either the 48 hour or 96 hour period, require certification by the ICM Managed Care Department or benefits may not be payable for the remainder of the hospital stay. Please see the "Newborns' and Mothers' Health Protection Act Notice" provision in the General Information section of the Plan.

Organ or Tissue Transplant

The covered person should contact the ICM Pre-admission Review Department as soon as reasonably possible following the date on which the covered person's attending physician has

indicated that the covered person is a potential candidate for an organ or tissue transplant or a potential donor for an organ or tissue transplant.

Pre-admission Review Non-compliance Penalty

If a covered person does not comply with the Pre-admission Review certification requirements, eligible charges for inpatient care will be covered as specified on the Schedule of Benefits.

Concurrent Stay Review

Concurrent Stay Review occurs while the covered person is in the hospital. If the ICM Managed Care Department is advised of the need for hospitalization for a longer period of time than that was certified by Pre-admission Review, the physician will be asked to provide the ICM Managed Care Department with additional medical information to evaluate the need for the extended stay.

If the covered person is confined in an inpatient facility longer than originally certified by the ICM Managed Care Department and the extended stay is not certified through the Concurrent Stay Review process, benefits may not be payable for the remainder of the hospital stay.

Medical Case Management

Medical Case Management focuses on acute or chronic conditions that result from serious or debilitating illnesses or injuries by coordinating the needs of the covered person, the family, the health care providers and the employer.

Second Surgical Opinion

If a covered person is obtains a second surgical opinion for an inpatient surgical procedure, eligible charges will be covered as specified on the Schedule of Benefits. The physician giving the second opinion must not be in medical practice with the physician who first recommended surgery. Charges are covered for a third opinion if the first and second opinions differ. After obtaining a second surgical opinion, it is the covered person's decision whether or not to have the surgery, no matter what the results are from the second opinion.

IMPORTANT: The utilization of Managed Care is not a guarantee of benefits under the Plan. Charges are subject to all Plan provisions.

INFORMATION REGARDING PPO AND NON-PPO PROVIDERS

The Plan Sponsor has entered into agreements with one or more preferred provider organizations. These preferred provider organizations are referred to as PPOs. PPOs contract with certain medical providers who agree to provide pre-determined medical services or supplies at prices that are typically less than the prices charged to individuals who are not covered by a PPO agreement. To determine if a particular medical provider participates in a PPO with which the Plan Sponsor has contracted, please contact the employer.

It is the choice of the covered person whether or not to use a PPO provider. The Plan, Plan Sponsor, and Third Party Administrator make no representations or warranties regarding the qualifications or the care provided by any provider, including those providers who participate in the PPO. Covered persons should make their own decisions concerning the qualifications of the providers they select to provide them with medical services or supplies.

SCHEDULE OF BENEFITS

The outline of benefits in this schedule is a summary of coverage provided by the Plan. A detailed explanation of the benefits is provided in the pages which follow.

Benefits listed in the Plan are limited to the Usual and Customary fees and subject to the Limitations and Exclusions specified in the Plan.

All inpatient hospital admissions are subject to the provisions of the Managed Care program.

Managed Care Benefits

Pre-admission Review Non-compliance Penalty	If a covered person does not comply with the Pre-admission Review certification requirements, the first $250.00 in eligible charges for inpatient care will not be payable. Any reduction in benefits will not apply toward satisfaction of the maximum coinsurance amounts and must be paid by the covered person even if the limitation on these expenses has been met.
Second Surgical Opinion	If a covered person obtains a second surgical opinion for an inpatient surgical procedure, eligible charges for the second opinion examination and related services are covered at 100% and are not subject to the deductible amount.

Comprehensive Medical Benefits

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Individual Deductible	$500	$1,500*	$3,500	Applies per person calendar year
Family Deductible Limit	$1,500	$4,500*	$10,500	Eligible charges for family members who are covered under the Plan may be applied toward satisfaction of the family deductible limit, however, no more than the individual amount specified any one individual will be applied toward the family deductible limit.
**** The additional deductible amounts only apply for Network Facilities not affiliated with the EPO Network.*** *EPO (Tier 1) Hospitals include: Parkview Hospitals, Parkview Noble, Parkview Whitley Hospital, Parkview LaGrange Hospital, Parkview Huntington Hospital, Parkview North Hospital, Orthopedic Hospital at Parkview North, Parkview Behavioral Health, Wabash County Hospital, Cameron Hospital, Adams County, Dekalb County Hospital.*				
PPO/Non-PPO Exceptions	Only under the following circumstances will benefits be determined at the EPO rather than the Non-PPO benefit level: **1.** when a covered person requires medical care and there is not an EPO provider available; **2.** when medical care is necessary due to an emergency. An emergency is defined as a sudden and severe onset of life threatening symptoms such as fainting, difficult breathing, chest pain, allergic reaction or accidental injury; **3.** when a covered person receives medical care at an EPO hospital or ambulatory surgical center and such facility utilizes the services of a Non-EPO radiologist, anesthesiologist, pathologist, or emergency room physician; or **4.** eligible charges for medical services for covered employees who reside outside the EPO Network are and their eligible dependents.			
Coinsurance Paid By the Plan	80%	80% or 60%*	40%	***Applies to facility fees not affiliated with the EPO Network.** All professional fees will remain at 80% unless otherwise specified by the Plan, up to the Maximum Allowable Amounts.

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Maximum Out-of-Pocket Amounts	Individual: $1,500 Family: $4,500	Individual: $3,500 Family: $10,500	No Limit	Unless otherwise specified by the Plan, after satisfaction of the out-of-pocket-amounts, eligible services will be covered at 100% for the remainder of the calendar year. Eligible charges for the following will not be applied toward satisfaction of the Maximum-Out-of-Pocket Amounts: • any deductible amounts; • any penalty amounts; • any preventative and/or routine care charges; • any chiropractic charges; • any charges not covered by the Plan; and • any changes for Mental Health and Substance Abuse. EPO Benefits can be applied toward the PPO benefit level.

Miscellaneous Benefits

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Chiropractic Care	Deductible/80%	Deductible/80%	Deductible/40%	Limited to a maximum of 20 visits or $2,000 per calendar year, which ever occurs first
Home Health Care	Deductible/80%	Deductible/80%, or 60%	Deductible/40%	Limited to a maximum of 60 visits per calendar year
Human Organ and Tissue Transplant	Deductible/80%	Deductible/80%	Deductible/40%	Limited to the Maximum Benefit of $10,000 for charges incurred for removal, preserving and transportation costs of the donated organ to the extent not covered by the donor's plan
Laboratory Expenses	Specialty Lab-(Acculab) 100%	Specialty Lab-(Acculab) 100%	Specialty Lab-(Acculab) 100%	
	Non-Specialty Lab Deductible/80%	on-Specialty Lab Deductible/60%	Non-Specialty Lab Deductible/40%	
Mental Health and Substance Abuse Treatment	*Inpatient Mental Health and Substance Abuse Treatment* Deductible/80%	Deductible/80%, or 60%	Deductible/60%	**Mental Health –** Inpatient/Transitional – limited to 30 days per calendar year **Outpatient** – limited to 50 visits per calendar year **Substance Abuse-** Inpatient and Outpatient- limited to a combined maximum of $5,000 per person per calendar year
	Outpatient Mental Health and Substance Abuse Treatment Deductible/50%	Deductible/50%	Deductible/50%	

- When multiple charges and diagnoses are received for outpatient services and supplies that have been provided for either or both Mental Health and Substance Abuse, outpatient benefits under the Plan will be determined according to the provider's primary diagnosis listed for that date of service.
- The determination of whether a claim for benefits is covered by and subject to the Mental Health benefit shall be made without regard to whether the cause of the condition for which treatment and supplies were provided is, or was, organic in origin.

Provision	Signature Care EPO Special Access Providers	Signature Care PPO Providers	Non-PPO Providers	Maximums/Notes
Skilled Nursing Facility	Deductible/80%	Deductible/80% or 60%	Deductible/40%	Limited to a maximum 90 days per confinement
Specialty Cardiac Expenses	Cardiac Pathways Program 100%	Non-Specialty Care Deductible/80%	Deductible/40%	
Supplemental Accident Benefit	100%	100%	100%	Limited to a maximum of $500 per accidental injury Treatment must be rendered within 90 days of the accident date and provided on an outpatient basis After exhaustion of the $500, eligible charges are subject to the deductible and coinsurance amount specified by the Plan
Temporomandibular Joint Dysfunction	Deductible/80%	Deductible/80%	Deductible/40%	Limited to the Maximum Benefit specified by the Plan
The Wellness Benefit	100%	100%	100%	Limited to a maximum benefit of $500 per calendar year. Thereafter, for the remainder of that calendar year, eligible charges will be covered subject to the deductible and coinsurance amounts specified by the Plan. The following routine services are covered: • Examinations; • Pap smears; • Mammograms, once per calendar year; • Other related lab and x-rays; • Well-baby care; and • Preventative immunizations.

Prescription Drug Benefits

Eligible prescription drugs are payable after satisfaction of the following co-payments:

Provision	Retail Program	Mail Order Program	Maximums/Notes
Prescription Drug Co-payment Amounts	Generic: $10 Preferred Brand: $30 Non-Preferred Brand: $45	Generic: $20 Preferred Brand: $60 Non-Preferred Brand: $90	Dispensing Limitations: Retail Program – not to exceed a 34-day supply* Mail Order – Not to exceed a 90-day supply
Retail Refill Allowance Program	Generic: $20 Preferred Brand: $60 Non-Preferred Brand: $90	n/a	*Limited to a maximum of 3 refills. The 4th refill is subject to the higher co-pay listed. This applies to maintenance prescriptions only.
Mandatory Generic Substitution	The covered person must use generic drugs when they are available, otherwise the covered person must pay the difference between the generic drug cost and the brand name drug cost, in addition to the brand name co-payment amount. If the provider issuing the written prescription or the state in which the covered person resides does not allow generic substitution, the covered person shall be required to pay only the brand name co-payment amount.		

Maximum Benefits

Maximum Benefits are applicable for the total period of time in which covered by the Plan.

All paid medical benefits - $1,000,000 per person, except as specified below.

Temporomandibular Joint Dysfunction - $2,000 per person**

Human Organ and Tissue Transplant – Donor Charges - $10,000 per person**

**This amount is included in, and is not in addition to, the all paid medical benefits amount specified above.

Any amounts paid by the Plan through the Prescription Drug Benefits program will reduce the Maximum Benefits amount.

Any amounts paid by the Plan through the Prescription Drug Benefits program will reduce the Maximum Benefits amount.

ELIGIBILITY FOR COVERAGE

Eligibility Provisions

Eligible Employees

All employees classified as regular full-time (hourly or salary) who are actively at work on a regular basis for the employer are eligible for coverage under the Plan. Temporary, seasonal, part-time, independent contractors, leased (even if determined to be common-law employees) and retired employees except as specified in the "Retired Employee Coverage Continuation" provisions are not eligible for coverage

Eligible Dependents

Eligible dependents include the following:

1. a lawful spouse of the employee who is a resident in the same country in which the covered employee resides, with the exception of a spouse who is eligible for medical expense insurance or becomes eligible under a plan sponsored by his/her employer (whether the spouse is currently covered or previously declined coverage under that plan);

a spouse who is eligible for medical expense insurance or becomes eligible under a plan sponsored by his/her employer (whether the spouse is currently covered or previously declined coverage under that plan);

2. each unmarried Child (as defined in subparagraphs a-e below) of the covered employee who is less than age 19 or who is at least age 19 but less than age 23 and meets the requirements of the "Full-time Student" provision specified below. Unless otherwise required by court order or divorce decree, the covered employee must provide more than one-half of the Child's support for the calendar year, unless otherwise required by a Qualified Medical Child Support Order ("QMCSO").

"Child" shall mean:

(a) a natural born son or daughter of the covered employee;

(b) a child for whom the covered employee has been appointed guardian by court order or a stepchild, provided the employee meets the support and maintenance requirements for the stepchild or ward as specified above and provided the stepchild or ward has not attained the limiting age requirements as specified above;

(c) a child who meets the requirements of the Handicapped Child provision specified below;

(d) a child who meets the requirements of the Adopted Child provision specified below; or

(e) a child who meets the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order provision specified below.

Full-time Student
A child is eligible for coverage under the Plan if he or she is attending an accredited school, college or university on a full-time basis. Full-time student status will be determined based upon the rules of the school, college or university.

A child who is an active full-time student on the day immediately prior to the end of a school term or semester may continue coverage under the Plan for a period not to exceed 120 days from the date on which the school's semester or term ended. If the child does not return to a school, college or university as a full-time student within the 120 day time period specified above, then coverage under the Plan will terminate on the date on which the 120 day period ended. The dependent may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision.

If a full-time student loses full-time student status during a school semester or term, then coverage under the Plan will terminate on the date on which the child lost full-time student status. The dependent may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision.

Coverage of Dependent Students on Medical Leave

If, while covered under the Plan, a Dependent student needs to reduce his/her course load or leave school due to a Medically Necessary leave of absence, the Dependent student may be eligible to continue coverage under the Plan.

Coverage will only be continued if We receive documentation of the Medical Necessity of the leave of absence from the Dependent's attending Physician. The date on which the Dependent ceases to be a full-time student due to the Medically Necessary leave of absence shall be the date on which the continuation of coverage begins.

Coverage will continue until the first of the following occurs:

1) We are advised that the Dependent does not intend to return to school full time.
2) The Dependent becomes employed full time.
3) The Dependent obtains other health care coverage.
4) The Dependent marries and is eligible for coverage under his or her spouse's health care coverage.
5) The Dependent reaches the age at which coverage as a Dependent who is a full-time student would otherwise end under the terms and conditions of this Plan.
6) Coverage of the Member through whom the person has Dependent coverage under this Plan is discontinued or not renewed.
7) One year has elapsed since the Dependent's continuation of coverage began and the Dependent has not returned to school full time.

Upon coverage termination, the dependent may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision.

Handicapped Child
A natural born child, an adopted child, a step-child or a child for whom the covered employee has been appointed guardian by court order who loses coverage under the Plan due to the child attaining an age that would terminate the child's coverage under the Plan,

may continue coverage under the Plan if and so long as the child meets all of the requirements as specified below:

1. the child has a mental or physical handicap that makes the child incapable of self-sustaining employment;
2. the covered employee who is the child's parent, step-parent or guardian must provide more than one-half of the child's support during the calendar year;
3. the child meets all other eligibility requirements of the Plan;
4. the covered employee who is the child's parent, step-parent or guardian is actively at work with the employer;
5. the child is unmarried; and
6. the child is covered as a dependent on the Plan on the day immediately prior to the date on which the child would lose coverage as a result of having attained an age which would otherwise make the child ineligible for coverage.

The child or the child's parent, step-parent or guardian shall provide satisfactory proof to the Plan Administrator that the conditions described above existed on the date the child would otherwise lose coverage as a result of having attained an age which would otherwise make the child ineligible for coverage. Such proof shall not be requested more than annually after the date the first proof was provided. If satisfactory proof is not submitted when it is due, the child's coverage will terminate on that date.

Adopted Child

Dependent children placed for adoption with a covered employee shall be eligible for coverage under the same terms and conditions as apply in the case of dependent children who are natural born children of covered persons under the Plan, irrespective of whether the adoption has become final.

As used in this section "Adopted Child" only, the term "child" means, in connection with any adoption, or placement for adoption of a child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption.

The terms "placement" or "being placed" for adoption in connection with any placement for adoption of a child with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

Coverage Pursuant to a Qualified Medical Child Support Order

The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" shall have the meanings given to them in Section 609 of the Employee Retirement Income Security Act.

An "Alternate Recipient" shall mean any child of a covered person who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such covered person.

A copy of the Qualified Medical Child Support Order procedures may be obtained without charge from the employer.

EFFECTIVE DATE OF COVERAGE

Effective Date of Coverage

Each employee who is an eligible employee and such employee's eligible dependents may become effective for coverage on the first day of the month following 30 days of continuous employment for the employer as an eligible employee. Written application to elect coverage under the Plan must be made no later than 30 days after the effective date of coverage. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Plan Participation

An eligible dependent cannot be covered under the Plan, unless the employee who is the dependent's spouse, parent, step parent or guardian is covered as an employee under the Plan or unless coverage is provided pursuant to an extension of coverage provision as provided in the Plan. However, this restriction does not apply to individuals properly electing COBRA coverage under the Plan. An eligible dependent cannot be covered under the Plan by more than one eligible employee. Also, an employee cannot be covered under the Plan as both an eligible employee and as an eligible dependent.

Transfer of Status

An individual who is covered under this Plan as either an employee or as a dependent may transfer to dependent or employee status under this Plan provided the individual is eligible for that coverage under this Plan and provided a lapse in coverage did not occur. In this instance, the waiting period shall not apply.

Working Spouse Provision

A working spouse eligible for medical expense insurance under a plan sponsored by the spouse's employer (whether the spouse is currently covered or previously declined coverage under that plan) is not eligible to enroll for coverage under the Plan, or continue coverage under the Plan. If a spouse's employer offers a medical plan for which the spouse is eligible, the spouse must elect to be covered under that plan. If the spouse elects not to participate in the spouse's employer's plan even though the spouse was eligible to do so, the spouse will not be eligible for dependent coverage under this Plan. If the spouse's employer does not offer a medical plan or if the spouse is not eligible for coverage under the spouse's employer's plan, the spouse will be eligible to be covered under this Plan.

Coverage for the Spouse under this Plan will be terminated or rescinded as follows:

1. if the Spouse fails to apply for and accept coverage under the Spouse's Employer's Group Health Plan and fails to make all reasonable efforts to secure such coverage, then coverage under this Plan will be rescinded effective on the date on which the

Spouse was eligible for coverage under the Spouse's Employer's Group Health Plan; or

2. if the Spouse is eligible for coverage under the Spouse's Employer's Group Health Plan and fails to maintain coverage under such plan, then coverage under this Plan will be rescinded effective on the date coverage was lost under the Spouse's Employer's Group Health Plan due to the Spouse's failure to maintain coverage or coverage under this Plan will terminate on the date on which coverage under the Spouse's Employer's Group Health Plan will terminate, if this Plan is notified of the loss of coverage in advance of that date; or

3. coverage under this Plan will be terminated or rescinded as provided elsewhere in this Plan.

Note: This Working Spouse Provision shall apply to the Spouse of a covered employee at anytime during which the Spouse becomes eligible for the Spouse's Employer's Group Health Plan, even after he or she becomes covered under this Plan.

This Working Spouse Provision will not apply in situations where both the employee and the Spouse are employees of the Employer and where both are eligible for a group health plan providing medical coverage offered by the Employer.

If the Spouse is no longer eligible for coverage under the Spouse's Employer's Group Health Plan for reasons other than:

1. a failure to make a timely application for coverage under that plan; or

2. a failure to take all reasonable efforts necessary to secure and maintain such coverage

then the Spouse may apply for coverage under the Plan provided an application for such coverage is made no later than 31 days after the date coverage is lost under the Spouse's Employer's Group Health Plan. If the Spouse is eligible for and has properly elected coverage under the Plan then, coverage will become effective on the date the Spouse lost coverage under the Spouse's Employer's Group Health Plan.

Special Enrollment Provisions

Loss of Coverage

An eligible dependent of a covered employee or an employee who is eligible for coverage under the Plan, may be permitted to enroll for coverage under the Plan if:

1. the employee stated in writing at the time that coverage was declined or terminated under this Plan that other coverage under a group health plan or health insurance coverage was the reason for declining enrollment or terminating coverage under this Plan, but only if at such time the Plan required such a written statement and the Plan

provided the employee with notice of the requirement (and the consequences of the requirement);

2. the employee or dependent at the time coverage under this Plan was declined or terminated by the employee or dependent:

a) was covered under a COBRA continuation provision and the coverage under such provision terminated for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan; or

b) was not covered under a COBRA continuation provision and either the coverage under the other group health plan or health insurance coverage was terminated as a result of:

- loss of eligibility for coverage (including loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment); or
- employer contributions toward such coverage were terminated; or
- the exhaustion of COBRA coverage if elected following such loss of eligibility under the other group health plan or health insurance coverage; and

3. the employee or dependent makes written application for coverage under the Plan no later than 31 days following the loss of coverage as described in 2(a) or (b) above.

Additionally, the employee or dependent must provide acceptable written evidence that health coverage under the other group health plan or group insurance existed, the names of the individuals who were covered under such group health plan, the level of coverage under the other group health plan or group insurance (individual or family), type of coverage (medical, dental, etc.) and the date the coverage terminated. Any applicable waiting period for coverage under the Plan must be satisfied before coverage becomes effective.

In such instances, coverage may become effective on the day after coverage under the other previous group health plan or health insurance coverage terminated and such person will not be considered a Late Enrollee as specified in the Pre-existing Condition Limitation section of the Plan.

If coverage is not available under this Loss of Coverage provision, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Family Status Change

An eligible dependent of a covered employee or an employee who is eligible for coverage under the Plan, may be permitted to enroll for coverage under the Plan if:

1. the employee is a covered person or the employee has met any waiting period applicable to becoming covered under the Plan and is eligible to be enrolled in the Plan, but when previously eligible, had declined enrollment for coverage under the Plan; and

2. a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption

then, the dependent acquired through marriage, birth, adoption or placement for adoption (and, if not otherwise enrolled, the employee) may be covered under the Plan as a dependent of the employee.

Upon the birth, placement for adoption or adoption of a child, a covered employee may elect coverage under the Plan for his/her spouse, if the spouse is otherwise eligible for coverage.

In these instances, written application to elect coverage under the Plan must be made within 31 days after the date of marriage, birth, adoption or placement for adoption. If coverage under the Plan is elected within this time period, coverage may become effective on the date of such marriage, birth, adoption or placement for adoption and such person will not be considered a Late Enrollee as specified in the Pre-existing Condition Limitation section of the Plan. If the employee has family coverage in effect on the date of birth of the employee's natural child, then such child may become effective for coverage on the date of birth and the requirement to make written application for coverage for the newborn child shall not apply. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Miscellaneous Enrollment Provisions

Annual Open Enrollment

During the December open enrollment period which is presently provided each calendar year:

1. a covered employee may make written application to elect coverage under the Plan for an eligible dependent; or

2. an eligible employee may make written application to elect coverage under the Plan for himself or herself and any eligible dependents provided the employee has met any applicable waiting period prior to becoming covered under the Plan.

The effective date of coverage will be January 1 following the enrollment period. The Pre-existing Condition Limitation - Late Enrollee provision shall apply. However, written application to elect coverage under the Plan may be made outside the open enrollment period as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Legal Guardianship

An eligible dependent child may become covered under the Plan on the date on which such child is placed in the covered employee's home pursuant to a court order appointing the covered employee as legal guardian for the child. The employee must make written

application to elect coverage under the Plan within 31 days of the date on which the child is placed in the employee's home pursuant to a court order appointing the employee as legal guardian for the child. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Qualified Medical Child Support Order

An eligible dependent child may become covered under the Plan on the date on which coverage is required to become effective pursuant to a Qualified Medical Child Support Order.

Paternity

Children born outside of marriage may become eligible dependents of a covered employee who is the father. The employee must make written application to elect coverage under the Plan within 31 days of:

1. the date of a court order declaring paternity; or
2. the date the acknowledgment of paternity is filed with the Department of Health and Social Services or its equivalent is filed with the equivalent agency in another state.

If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Extension of Active Service Provisions

Approved Medical Leave of Absence – Firefighters Only

If a medical leave of absence is approved by the employer due to disability, or illness, coverage may continue during the leave of absence to a maximum of 365 days from the date in which the leave began, provided the employees wages are continued by the employer. If the employee does not return to full-time employment within 365 days following the date on which the leave began or upon expiration of the approved leave, whichever is the earlier to occur, coverage under the Plan will terminate. The employee may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision. The period of extended coverage provided for here, will run concurrently with and not in addition to any other extended coverage taken.

Approved Paid Leave of Absence

If a personal leave of absence is approved by the employer due to disability, a personal leave, or a layoff, coverage may continue during the leave of absence to a maximum of 180 days from the last day of the month in which the leave began, provided the employee’s wages are continued by the employer. If the employee does not return to full-

time employment within 90 days following the date on which the leave began or upon expiration of the approved leave, whichever is the earlier to occur, coverage under the Plan will terminate. The employee may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision. The period of extended coverage provided for here, will run concurrently with and not in addition to any other extended coverage taken.

Approved Unpaid Leave of Absence

If a personal leave of absence is approved by the employer due to disability, a personal leave, or a layoff, coverage may continue during the leave of absence to a maximum of 30 days from the last day of the month in which the leave began. If the employee does not return to full-time employment within 30 days following the date on which the leave began or upon expiration of the approved leave, whichever is the earlier to occur, coverage under the Plan will terminate. The employee may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision. The period of extended coverage provided for here, will run concurrently with and not in addition to any other extended coverage taken.

Family and Medical Leave Act of 1993

Employees who are covered under the Plan and who have been granted leave ("Leave") pursuant to the Family and Medical Leave Act of 1993 (the "Act"), will have coverage under the Plan for the duration of the Leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the Leave.

During a Leave, an employee's participation in the Plan may terminate as a result of non-payment of the employee contribution required in order to participate in the Plan. Upon the eligible employee's timely return from Leave as specified by the employer, the employee's coverage under the Plan (including coverage for eligible dependents if covered under the Plan at the time coverage terminated) will become effective on the date of the eligible employee's actual return to work, provided written application to elect coverage under the Plan is made within 31 days of the date the employee returned to work. In such instances the waiting period will not apply and the pre-existing condition limitation will apply to the extent not previously satisfied. However, the Plan will not be required to pay for any charges incurred during the period in which coverage was terminated under the Plan. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Retired Employee Coverage Continuation Provision – Public Safety Employees

A covered employee who retires from employment and any eligible dependents, are eligible to continue coverage under the Plan provided the retired employee has elected to receive his/her pension benefit. The employee and his/her eligible dependents may remain covered under the Plan until he or she attains age 65, or becomes eligible for

Medicare. A retired employee must make election to continue coverage within 90 days from the date of retirement. The continued coverage will become effective on the date such employee retired. The employee may elect to continue coverage for his or her spouse and dependents who were covered by the Plan on the date of the employee's retirement.

In the event of the death of the retired employee, the spouse and dependents who were covered by the Plan on the employee's retirement date may remain covered by the Plan until the lesser of: (a) the date on which the spouse or eligible dependents become eligible for Medicare; (b) the date on which the spouse remarries; (c) the date on which the spouse or eligible dependent cease to meet the definition of an eligible dependent as specified by the Plan; or (d) the date (2) two years after the date of the death of the retired employee. Upon termination of coverage, the dependent children may, in certain instances, be eligible to continue coverage through the COBRA Continuation Coverage provision. This period of extended coverage shall run concurrently with, and not in addition to, the COBRA Continuation Coverage provision.

Retired Employee Coverage Continuation Provision – Civilian Employees

A covered employee who retires from employment and is collecting his/her pension, is eligible to continue coverage under the Plan. The employee may remain covered under the Plan until he or she attains age 65, or becomes eligible for Medicare. A retired employee must make election to continue coverage within 90 days from the date of retirement. The continued coverage will become effective on the date such employee retired.

The retired employee's dependent spouse and children may continue coverage under the COBRA Continuation Coverage provision.

Reinstatement Provisions

Reinstatement of Coverage

An employee's coverage under the Plan may be reinstated if such coverage terminated due to termination of employment with the employer and the employee returns to active employment as an eligible employee for the employer within 62 days from the date on which employment terminated. Coverage under the Plan will become effective on the date of return to active employment as an eligible employee. The employee must make written application to elect coverage under the Plan within 30 days following the date of return to active employment. The Pre-existing Condition Limitation will apply to the extent not previously satisfied. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Full-time Student Reinstatement of Coverage

A dependent child of a covered employee may be reinstated for coverage under the Plan, if the child's coverage under the Plan terminated because the child ceased to meet the

requirements of the Plan's Full-time Student provision and subsequently the child regains status as an eligible full-time student and satisfies the other eligibility requirements of the Plan. Coverage under the Plan will become effective on the date on which the child is enrolled and accepted as a full-time student by the school, college or university. Written application for coverage must be made within 30 days of the date on which the child becomes an eligible full-time student. The Pre-existing Condition Limitation of the Plan will apply. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll the dependent child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Uniformed Service Employment and Reemployment Rights Act (USERRA)

The Uniformed Service Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that all employers provide a cumulative total of five years, and in certain instances more than five years, of military leave during an employee's employment with the employer.

Continuation of Coverage During a Military Leave

The law requires that an employer continue to provide coverage under this Plan during a military leave that is covered by the Act for you or your dependents. The coverage provided must be identical to the coverage provided under the employer's plan to similarly situated, active employees and dependents. This means that if the coverage for similarly situated, active employees and dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the employee contribution required for active employees;
2. For military leaves of 31 days or more, up to 102% of the full cost of the coverage, e.g., the employee and employer share.

Continuation coverage rights apply to medical, dental, prescription drug and other health coverages. Short and long term disability and life benefits are not subject to continuation rights.

Continued coverage provided under USERRA will reduce any continuation provided under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to return to Employment with the Company following completion of your military leave. Employees must return to employment within:
   - **a)** The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   - **b)** 14 days after completing military service for leaves of 31 to 180 days,

c) 90 days after completing military service, for leave of more than 180 days; or

2. **a)** 18 months from the date your leave began, if coverage was elected to begin prior to December 10, 2004; or

b) 24 months from the date your leave began, if coverage was elected to begin on or after December 10, 2004.

Reinstatement of Coverage Following Military Leave

The law also requires, regardless of whether continuation coverage as stated above was elected, that your coverage and your dependents coverage be reinstated immediately upon your honorable discharge from military service and return to employment, if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;

2. 14 days of completing your military service, for leaves of 31 to 180 days; or

3. 90 days of completing your military service, for leaves of more than 180 days.

If, due to a sickness or injury caused or aggravated by your military service, you cannot return to work within the times stated above, you may take up to a period of two years, or as soon as reasonably possible if for reasons beyond your control you cannot return within two years, to recover from such sickness or injury and return to employment within the times stated above.

If your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continual under the Plan. The eligibility period will be waived and the Pre-Existing Condition Limitation will be credited as if you had been continually covered under the Plan from your original effective date.

This waiver of limitations does not provide coverage for any sickness or injury caused or aggravated by your military service, as determined by the Secretary of Veterans Affairs.

TERMINATION OF COVERAGE

An employee's or dependent's coverage will terminate upon the earliest of the following occurrences:

1. the date of termination of the employee's employment;

2. the date on which the employee or dependent cease to be in a class eligible for coverage;

3. the effective date on which a modification of the Plan terminates coverage for the class of employees or dependents to which the employee or dependent belongs;

4. the date of termination of the Plan;

5. the date on which the employee designates to terminate coverage under the Plan;

6. the end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due;

7. the date on which a covered person enters service in the Uniformed Services on an active duty basis, other than for scheduled drills or other training of less than 31 days, unless coverage continuation has been elected under the Uniformed Services Continuation and Reinstatement;

8. the date on which the employee or dependent no longer meet the eligibility requirements of the Plan;

9. the date on which a dependent ceases to meet the definition of a dependent;

10. a) the date on which any extension of coverage (including a leave of absence) as described in the Extension of Active Service Provisions of the Plan expires; or

b) for any extension of coverage (including a leave of absence) as described in the Plan which runs concurrently with the Continuation of Coverage (COBRA) provision, coverage will end on the date the extension of coverage (including a leave of absence) begins, unless otherwise specified in such provision;

11. as to any particular benefit, the effective date on which coverage for the benefit is eliminated by amendment to the Plan; or

12. the date as stated in the provision entitled “Rescission of Coverage” in the General Information section of the Plan.

COBRA CONTINUATION COVERAGE

This COBRA continuation coverage section of the Plan is intended to comply with and satisfy the Notice requirements of § 2590.606-1(e) of title 29 of the Federal Regulations.

This COBRA continuation coverage section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section will generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you or they would otherwise lose group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

What is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

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 or her gross misconduct;
4. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

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

When is COBRA Continuation Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Qualifying Event: FMLA
If an employee does not return to work at the end of the employee's leave under the Family and Medical Leave Act or states that he/she will not be returning at the end of the leave period and the employee was covered under the Plan on the day before the first day of the leave or became covered during the leave, the employee will, on the first day after the end of his/her leave or as of the date the employee provides unequivocal notice of his/her intent not to return to work (as appropriate), be deemed to have experienced a "Qualifying Event" for purposes of COBRA continuation coverage if in the absence of COBRA continuation coverage the employee would lose coverage under the Plan before the end of the maximum coverage period. A qualifying event will not occur if coverage is eliminated under the Plan on or before the last day of the Employee's leave for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken leave.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the occurrence of any of these qualifying events.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice on a timely basis that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing

eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Election of Coverage
Each dependent who is a Qualified Beneficiary has an independent right of election under the Plan. If either the Covered Employee or the Qualified Beneficiary who is the spouse of a Covered Employee makes an election for COBRA continuation coverage but does not specify whether the election is for single or other coverage, then the election will be deemed to cover all eligible Qualified Beneficiaries. If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In general, a Qualified Beneficiary is only entitled to elect the same type of coverage in effect immediately before the Qualifying Event. However, a Qualified Beneficiary has the same right to change from family to single coverage.

A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, COBRA continuation

coverage is subject to the Qualified Beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate a Qualified Beneficiary's COBRA continuation coverage retroactively if the Qualified Beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA Beneficiaries the coverage under the Plan will be modified in the same manner for all Qualified Beneficiaries covered under the Plan.

COBRA continuation coverage commences on the day of the Qualifying Event if COBRA continuation coverage is properly elected and the applicable premium is paid as specified herein.

If a Qualified Beneficiary initially elects not to continue coverage under COBRA, the Qualified Beneficiary may revoke that non-election of COBRA continuation coverage at any time during the 60 day election period. The Plan, however, will only provide COBRA continuation coverage beginning with the date of the revocation of the non-election and not retroactively to the date of the actual Qualifying Event. This will result in a lapse of continuous coverage under the Plan. Qualified Beneficiaries must provide notice of the election of COBRA continuation coverage in writing.

If COBRA Continuation Coverage is rejected in favor of alternate coverage under the Plan, COBRA Continuation Coverage will not be offered at the end of that period. If alternate coverage is offered, the COBRA Continuation Coverage period will be reduced to the extent such coverage satisfies the requirement of COBRA. Alternate Coverage may include, for example, continuation by USERRA or any other Plan provision or retiree coverage.

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

Termination of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the end of the 18, 29 or 36 month period for the following reasons:

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for COBRA continuation coverage is not paid by the Qualified Beneficiary on a timely basis or within any applicable grace period.
3. The Qualified Beneficiary becomes covered under another group health plan or entitled to Medicare (either Medicare Part A or Part B, whichever comes first) after the date of the Qualified Beneficiary's election, even if that coverage is different than coverage currently in place. If the Qualified Beneficiary has a condition which is not covered under the other group health plan because the other group health plan contains a pre-existing condition limitation, then the Qualified Beneficiary may continue COBRA continuation coverage under the Plan for the period of time which he or she is denied coverage under the other group health plan for the pre-existing

condition, but no longer than the COBRA continuation coverage period for which the Qualified Beneficiary is eligible. (Coverage under the Plan will not be permitted if the other group health plan contains a pre-existing condition exclusion or limitation which does not apply to the Qualified Beneficiary by reason of the other group health plan's portability, access and renewability provision restricting the application of the pre-existing condition limitation.)

4. The Plan terminates coverage on the same basis that the Plan terminates coverage of similarly situated non-COBRA Qualified Beneficiaries.

5. For a Qualified Beneficiary who has continued COBRA continuation coverage due to Social Security Administration Disability status as a Covered Employee or as a Covered Dependent of a Covered Employee, the date on which the Qualified Beneficiary is no longer considered to be disabled by the Social Security Administration. However, such a determination does not allow termination of the COBRA continuation coverage of a Qualified Beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension. In this case the Qualified Beneficiary must notify the Plan Administrator within 30 days of the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. COBRA continuation coverage will be terminated on the first day of the month following 30 days after the date of the Social Security Administration's determination.

6. The Qualified Beneficiary is determined to have been ineligible for coverage under the Plan or is determined not to be a Qualified Beneficiary.

Payment of Premium

The Plan will require payment of a premium for COBRA continuation coverage. The premium will not exceed 102% of the applicable premium for the period in question except for the 11 months of a disability extension. If the disabled Qualified Beneficiary is qualified for and elects the disability extension, a premium not to exceed 150% of the applicable premium may be charged. If only the non-disabled family members of the disabled Qualified Beneficiary elect the disability extension, then they will be charged a premium not to exceed 102% of the applicable premium. In addition, the premium payment for the first 30 days for an employee who is eligible for coverage under the Uniformed Services Employment and Re-employment Rights Act of 1994 must be the same as for an active employee. Thereafter, the premium amount will not exceed 102% of the applicable premium for the remaining 17 months.

Determination of the applicable premium will be made in advance and will apply for a period of 12 months, the date being established by the employer, unless: 1.) The Plan has previously charged less than the maximum amount it is permitted to charge and the increased amount does not exceed the maximum amount permitted to be charged; or 2.) The increase occurs during the disability extension and the increased amount to be paid does not exceed the maximum amount permitted to be charged; or 3.) A Qualified Beneficiary changes the coverage being received.

The premium will be based in part, on a reasonable estimate of the cost of providing coverage for the period for similarly situated active employees or on the basis of past costs of providing such coverage.

The employer must allow the Qualified Beneficiary or a third party to pay for such COBRA continuation coverage on a monthly basis. The Qualified Beneficiary has 45 days from the date on which the Qualified Beneficiary makes a written election of COBRA continuation coverage to pay for the first month's premium. The initial premium payment must include all past amounts to the date of election and shall apply to the period of COBRA continuation coverage beginning immediately after the coverage under the Plan terminates except for cases where the Qualified Beneficiary does not elect to continue coverage and then revokes that non-election.

The Plan is not required to pay for any claims incurred prior to a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage, however, such claims shall be eligible for payment upon timely election of such COBRA continuation coverage and proper premium payment for the COBRA continuation coverage.

After the first month's COBRA continuation coverage under COBRA, the Qualified Beneficiary has a 30 day grace period from the first day of the coverage period in which to make payment. The employer or Plan Administrator will not send a bill each month. The Qualified Beneficiary or designated representative, is required to remit payment of the applicable premium to the employer or to the address specified in the COBRA notice on the date established by the employer. If payment is not received within the amount of time specified by the employer, and after the grace period has expired, COBRA continuation coverage will terminate. If the premium payment made by the Qualified Beneficiary is short by an amount not significantly less than the applicable premium, the Qualified Beneficiary will receive a notice of the deficiency and will have 30 days from the date of the notice for the deficiency to be paid.

If payment is made by check and that check is returned to the employer by the bank on which such payment is drawn for Non-Sufficient Funds, the Qualified Beneficiary has until the end of the applicable grace period to properly fund this payment. A check returned to the employer for any reason that is not funded prior to the end of the grace period will not be considered to be a timely payment of the applicable premium and COBRA continuation coverage under the Plan will terminate.

For purposes of COBRA continuation coverage, all benefits provided by this Plan shall be deemed to be one, single plan. (Short Term Disability and Long Term Disability benefits, if any, shall not be deemed a part of this Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor’s Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan 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 Plan Administrator.

Plan Contact Information
Information about the Plan and COBRA continuation coverage can be obtained from the Plan Administrator. Please refer to the Plan Information section of the Plan for the address and telephone number of the Plan Administrator.

PRE-EXISTING CONDITION LIMITATION

Definitions
The following terms will have the definitions indicated below for purposes of this Pre-existing Condition Limitation section.

"Affiliation Period" means a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which time the HMO is not required to provide benefits.

"Certificate of Coverage" means a document provided by the group health plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the covered person that indicates the amount of Creditable Coverage the individual acquired under the plan or the group health coverage.

"Creditable Coverage" means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.732(a).
(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).
(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).
(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).
(vi) A medical care program of the Indian Health Service or of a tribal organization.
(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means:
(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;
(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or
(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition:
(1) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(2) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan 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.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

"Enrollment Date" means, with respect to a covered person the earlier of, the individual's first day of coverage in the Plan, or with respect to a person who is eligible for coverage, the individual's first day of a Waiting Period, if there is a Waiting Period.

"Excluded Coverage" means:

1. coverage consisting of coverage only for accidents "including" accidental death and "dismemberment", disability income insurance, liability insurance "including" general liability insurance and automobile liability insurance, coverage issued as a supplement to a liability policy, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance and coverage for an on-site medical clinic;

2. coverage provided by limited scope dental, vision or long term care benefits if they are provided in a separate policy, certificate or contract of insurance or are otherwise not an integral part of a plan;

3. coverage for only a specified disease or illness or hospital indemnity or other fixed dollar indemnity insurance; or

4. medical supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act also known as "Medigap" or "MedSupp" insurance.

"Late Enrollee" means an individual who enrolls for coverage under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan; or

2. a special enrollment period. [See "Special Enrollment Provisions" in the Effective Date of Coverage section of the Plan.]

"Pre-existing Condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, prescription drugs, care

or treatment was recommended or received within the preceding 180-day period ending on the enrollment date. Such medical advice, diagnosis care or treatment must have been provided by a health care provider or practitioner duly licensed to provide such care under state law and operating within the scope of practice authorized by state law.

"Significant Break in Coverage" means a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage. Neither a Waiting Period nor an Affiliation Period is taken into account in determining a significant break in coverage.

"Waiting Period" means the period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

Pre-existing Condition Limitation
The covered person is not covered for a Pre-existing Condition until 365 days after the covered person's Enrollment Date.

Pre-existing Condition Limitation - Late Enrollee
The covered person is not covered for a Pre-existing Condition until 545 days after the covered person's Enrollment Date, if the covered person is a Late Enrollee.

Elimination of the Pre-existing Condition Limitation for Pregnancy and Certain Children
No Pre-existing Condition Limitation shall be imposed in the case of a covered person who, as of the last day of the 31 day period beginning with his or her date of birth was, covered under Creditable Coverage, unless such person would have a Significant Break in Coverage.

No Pre-existing Condition Limitation shall be imposed in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 31 day period beginning on the date of the adoption or placement for adoption, was covered under Creditable Coverage, unless such person would have a Significant Break in Coverage. Creditable Coverage shall not be recognized for coverage that occurred before the date of such adoption or placement for adoption.

NOTE: The preceding two paragraphs shall not apply to an individual after the end of the first 63 day period during all of which the individual had not been covered under any Creditable Coverage.

Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition relating to such information.

No Pre-existing Condition Limitation shall be imposed relating to pregnancy as a Pre-existing Condition.

No Pre-existing Condition Limitation shall be imposed on a covered newborn or a covered adopted child provided written application for coverage under the Plan was made for the child when first eligible.

Creditable Coverage

The period of any Pre-existing Condition Limitation under the Plan that would otherwise apply to a covered person is reduced by the number of days of Creditable Coverage such individual had as of the enrollment date subject to the following:

1. days of Creditable Coverage that occur before a Significant Break in Coverage will not be counted toward satisfying any Pre-existing Condition Limitation provision of the Plan;
2. the amount of Creditable Coverage is determined by counting all of the days the individual had Creditable Coverage from one or more sources, provided that any days in a Waiting Period for a plan or policy are not considered Creditable Coverage under the Plan; and
3. any coverage that is "Excluded Coverage" shall not be included as Creditable Coverage.

Evidence of Creditable Coverage

In determining the validity and amount of Creditable Coverage (and any applicable Waiting Period), the Plan may rely upon a Certificate of Coverage evidencing Creditable Coverage through presentation of a document or other means. The Plan may also, when an acceptable Certificate of Coverage is unavailable, take into account all information that it obtains or that is presented on behalf of a covered person to make a determination, based on the relevant facts and circumstances, whether a covered person has Creditable Coverage. The Plan shall treat the individual as having furnished a Certificate of Coverage if the individual attests to the period of Creditable Coverage in a manner acceptable to the Plan, the individual also presents relevant corroborating evidence of some Creditable Coverage during the period, and the individual cooperates with the Plan's efforts to verify the individual's coverage.

A covered person has a right to receive a Certificate of Coverage from the individual’s prior plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the covered person. If necessary, the Plan will assist the covered person in obtaining a Certificate of Coverage from any prior plan or from the insurance company, insurance service organization or organization that provided Creditable Coverage to the covered person.

Procedure for Certificates of Coverage

An individual who wishes to receive a Certificate of Coverage for periods under this Plan should contact the Plan Administrator whose address is given in the "Plan Information" section of the Plan.

Appeal Process for Determination of Creditable Coverage

A covered person who wishes to appeal an adverse determination of his or her Creditable Coverage by the Plan may appeal the determination by following the procedures in the provision entitled "Benefit Claim Procedures and Appeal Procedures for Claims" in the General Information section of the Plan. In such instances, an appeal of an adverse determination of Creditable Coverage will be handled in the same manner as if the adverse determination was a denial of a claim for benefits under the Plan.

COMPREHENSIVE MEDICAL BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Hospital Room and Board

Eligible hospital charges are those incurred for semi-private rooms, wards, intensive care and coronary care units. Eligible charges for a private room are limited to the average semi-private room rate for the facility where confined. When the facility has private rooms only or a private room is medically necessary, the private room rate will be considered.

Hospital Miscellaneous Charges

Eligible charges are covered for medically necessary services and supplies which are provided while hospital confined. Eligible charges are covered for visits made by a physician or medical specialist while confined in a hospital or skilled nursing facility. Personal items which are not medically necessary are not covered.

Outpatient Facility Services

If a covered person receives care in the outpatient department of a hospital, clinic or in an approved ambulatory surgical center, eligible charges for outpatient services include, for example, the following:

1. surgery;
2. treatment of an accidental injury;
3. treatment of a condition requiring medical care;
4. radiation, x-ray and chemotherapy; and
5. pre-admission testing.

Ambulance

Eligible charges are covered for local professional land or air ambulance service. Transportation must be to the nearest hospital qualified to provide treatment for the injury or illness. If the injury or illness requires special treatment which is not available in a local hospital, transportation to the nearest hospital equipped to provide treatment is covered.

Surgical Services

Eligible charges are covered for surgery when performed in a hospital, outpatient department of a hospital, ambulatory surgical center or clinic. Eligible charges include hospital pre-operative and post-operative care. Eligible charges for surgical services include, for example, the following:

1. cosmetic surgery required as a result of an accidental injury;

2. functional repair or restoration of any body part when necessary to achieve normal body function;
3. charges for an assistant surgeon;
4. charges for an elective sterilization for a covered employee or covered dependent spouse; and
5. abortion procedures for a covered employee or covered dependent spouse when the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of rape or incest.

Oral Surgery

Eligible charges are covered for the following oral surgical procedures:

1. surgical extraction of impacted third molar teeth;
2. excision of exostosis of the jaw and hard palate;
3. excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. surgery to correct accidental injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
5. reduction of fractures and dislocation of the jaw;
6. external incision and drainage of cellulitis;
7. incision of accessory sinuses, salivary glands or ducts; and
8. frenectomy.

Anesthesia

Eligible charges are covered for anesthesia and its administration when rendered by a provider who is licensed to perform these services.

Maternity Charges

Eligible charges are covered for medical care in connection with pregnancy, childbirth or a related medical condition of a covered employee or covered dependent spouse. Charges for dependent child maternity are not covered.

Newborn Coverage

Eligible charges for inpatient care of a newborn infant of the covered employee or covered dependent spouse include, for example, the following:

1. hospital nursery room, board and care;
2. necessary x-ray and laboratory services;
3. physician's visits;
4. charges for circumcision;

5. treatment for premature birth; and
6. necessary surgery to repair or restore a body part to achieve normal function.

Hospice Care

If a physician certifies that a covered person is terminally ill, eligible charges for Medicare certified hospice care are covered. Hospice care emphasizes the management of pain and other symptoms associated with terminal illness.

Other Covered Treatment, Services and Supplies

Eligible charges are covered for the following:

1. examinations when rendered for the diagnosis and treatment of an illness or injury;
2. diagnostic x-ray, laboratory, and related radiology and pathology services when rendered for the diagnosis and treatment of an illness or injury;
3. blood or blood plasma, other than the covered person's or that which has been donated specifically for the covered person;
4. physical, vision, occupational and speech therapy when rendered by a licensed therapist. Speech therapy is covered only when the therapy is medically necessary due to an accidental injury, surgery or organic pathological disorder such as a stroke;
5. initial purchase of prosthetic devices and supplies, including artificial limbs, eyes, larynx and orthotic appliances which replace an absent or malfunctioning body part or organ. Repairs are covered when needed to restore proper function;
6. casts, splints, trusses, orthopedic braces, crutches, dressing, and sutures;
7. treatment to sound natural teeth due to an accidental injury, other than those caused by chewing food or similar substances. Expenses must be incurred within 12 months from the date of injury;
8. charges for blood tests to detect lead exposure in children under six years of age, as may be required or indicated by applicable medical protocols;
9. eligible charges are covered for services provided by a hospital or ambulatory surgical center and for anesthesia charges provided in conjunction with dental care if any of the following apply:
    - **a)** the covered person is under age five;
    - **b)** the covered person has a medical condition that requires hospitalization or general anesthesia for dental care; or
    - **c)** the covered person has a chronic disability which meet all of the following conditions:
        - it is attributable to mental or physical impairment or combination of mental and physical impairments;
        - it is likely to continue indefinitely; and

- it results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency;

10. special supplies when prescribed by the attending physician such as:

- catheters;
- colostomy bags, rings and belts;
- flotation pads; and
- diabetic supplies (i.e., GlucoWatch and sensors), including one insulin infusion pump each calendar year if the covered person has used that pump for a minimum of 30 days;

11. rental (not to exceed purchase price) or purchase of durable medical equipment, such as wheelchairs, hospital-type beds, iron lung, oxygen equipment (including oxygen) and other durable medical equipment. Durable medical equipment is equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose; and
- generally is not useful to a covered person in the absence of an illness or injury.

12. eligible charges for medical equipment which is prescribed by a physician will be covered while the covered person is receiving medical care. Eligible charges are limited to the least expensive item which is adequate for the covered person's needs. Repairs are covered when needed to restore proper function;

13. charges for private duty nursing by an RN, or a Licensed Practical Nurse;

14. the first purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery;

15. services and supplies which are cosmetic and are required as a result of an accidental injury. Treatment needed to achieve bodily function is covered;

16. injections of medication related to a covered illness or injury;

17. charges to establish an initial diagnosis of infertility;

18. charges for injectable contraceptives such as Depo-Provera and implantable contraceptives such as Norplant;

19. charges for Interferon beta-1b (Betaseron) and Avonex;

20. hospital, surgical and other necessary medical charges, including rental of kidney dialysis equipment incurred for kidney dialysis treatment;

21. charges for a voluntary second surgical opinion;

22. charges for taxes and surcharges which are directly associated with the receipt or provision of covered services to the covered person; and

23. charges for and related to a mastectomy, including:

a) reconstruction of the breast on which the mastectomy has been performed;

b) surgery and reconstruction of the other breast to produce a symmetrical appearance when performed in connection with a mastectomy; and

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

MISCELLANEOUS BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits and are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Supplemental Accident Benefit

Eligible charges are covered as specified on the Schedule of Benefits when incurred as a result of an accidental injury. Eligible charges for treatment must be incurred within 90 days of the accident date and provided on an outpatient basis. Thereafter, eligible charges will be covered as otherwise specified by the Plan.

Inpatient, Outpatient and Transitional Treatment of Mental Health and Substance Abuse

Eligible charges for inpatient, outpatient and transitional treatment for Mental Health and Substance Abuse are covered as specified on the Schedule of Benefits. Treatment must be rendered in a facility approved or licensed in the state in which it is located.

Outpatient services include partial hospitalization privileges and collateral interviews with the family of the covered person receiving treatment. Treatment must be related to the diagnosed condition.

Skilled Nursing Facility

Eligible charges for care rendered in a licensed skilled nursing facility are covered as specified on the Schedule of Benefits. The covered person must enter a licensed skilled nursing facility within 14 days after discharge from a hospital confinement or a related confinement in a skilled nursing facility. Care must be medically necessary as certified by the attending physician every seven days and must be for the same condition as treated in the hospital or previous skilled nursing facility. The daily rate will not exceed the rate established for such care by the Department of Health and Human Services.

Home Health Care

Eligible charges for home health care are covered as specified on the Schedule of Benefits and are those charged by a home health care agency for:

1. evaluation of the need for, and development of, a plan by a registered nurse or medical social worker when approved or requested by the attending physician;
2. part-time or intermittent home nursing care rendered by or under the supervision of, a registered nurse;
3. part-time or intermittent services of home health aides which are:
    - **(a)** medically necessary as part of the home health care plan;
    - **(b)** under the supervision of a registered nurse or medical social worker; and
    - **(c)** which consist solely of caring for the covered person;

4. physical, respiratory, occupational and speech therapy;
5. medical supplies, drugs and medicines prescribed by the attending physician, if necessary under the home health care plan, but only to the extent such items would have been provided under the Plan had the covered person been hospitalized; and
6. nutritional counseling provided by, or under the supervision of, a registered dietitian when the services are medically necessary as part of the home health care plan.

Each visit by a provider of home health care of four hours or less is considered one visit.

Limitations

Home health care services do not include:

1. services or supplies not included in the home health care plan;
2. services of a family member;
3. custodial care;
4. food, housing, homemaker services or home delivered meals; or
5. transportation services.

Chiropractic Care

Eligible charges for chiropractic care including x-rays, manipulations and supportive care are covered as specified on the Schedule of Benefits. Supportive care means treatment which is medically necessary to prevent the covered person's condition from significantly deteriorating.

Laboratory Expenses

Eligible charges for laboratory services are covered as specified on the Schedule of Benefits. When the eligible services are provided through the specialty network indicated on your group employee benefit card, benefits are paid at a higher level

Temporomandibular Joint Dysfunction

Eligible charges are covered as specified on the Schedule of Benefits for the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ), provided the condition is caused by a congenital developmental or acquired deformity disease or injury; the procedure or device is medically necessary for the diagnosis or treatment of the condition; and the purpose of the procedure or device is to control or eliminate infection, pain, disease or dysfunction. Non-surgical treatment includes coverage for prescribed intraoral splint therapy devices. Cosmetic or elective orthodontic care, periodontics care or general dental care is not covered. Charges are subject to all provisions of the Plan.

Specialty Cardiac Expenses

Eligible charges for cardiac services are covered as specified on the Schedule of Benefits. When the eligible services are provided through the specialty cardiac network indicated on your group employee benefit card, benefits are paid at a higher level.

Human Organ and Tissue Transplant

Eligible charges are covered as specified on the Schedule of Benefits for human organ and tissue transplants if the transplant procedure is not Experimental or Investigational. When a donor or recipient is involved, charges are covered as follows:

1. when both the recipient and the donor are covered by the Plan, each is entitled to benefits under the Plan;
2. when only the recipient is covered by the Plan, the covered person who is the recipient is entitled to the benefits under the Plan and the donor is entitled to certain limited benefits as specified by the Plan. In this instance, for the donor, only those eligible charges for services to donate the human organ or tissue will be covered. The donor will be eligible for these specified benefits under the Plan only if such charges are not covered for the donor from any other source, including for example, any insurance coverage, employee benefit plan or government program. Eligible donor charges covered by the Plan will accumulate toward any maximum applicable to the covered person who is the recipient; or
3. when only the donor is covered by the Plan, the donor is entitled to the benefits of the Plan, however, any other source of coverage available to the donor will be considered the primary payor of benefits and this Plan will be the secondary payor of benefits.

Eligible charges related to an organ or tissue transplant include for example hospitalizations, supplies and medications which are dispensed while either an inpatient or outpatient in a medical facility and those related to the evaluation and/or procurement of the organ or tissue. Benefits will not be duplicated if they are available from another plan, an organization or Medicare.

Special Transplant Benefit

In addition to any standard transplant benefit stated in the Plan, a special transplant benefit may be available when a covered person participates in the Special Transplant Program. This Special Transplant Benefit provides enhanced transplant benefits, and participation in the program is voluntary. Additional information regarding the Special Transplant Program may be obtained through the employer or the Individualized Care Management (ICM) Managed Care Department.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this Plan:

Additional Covered Benefits

1. access to Centers of Excellence Transplant Facilities throughout the United States;
2. reimbursement, up to a total of $5,000, for expenses incurred by the covered person and one companion, or both parents if the covered person is a minor child;

    a) for travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and

    b) for lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence; and

3. waiver of the covered person's deductible and co-payments, up to $1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a covered person participates in the Special Transplant Program and satisfies all of the following requirements:

1. pre-certification must be obtained from Individualized Care Management (ICM) Managed Care Department in accordance with its guidelines;
2. as soon as the covered person is identified as a potential candidate the covered person, their physician, or Individualized Care Management (ICM) Managed Care Department must call the Special Transplant Program at 1-888-4ORGANS (or call the number on the back of the covered person's insurance identification card) to notify the Special Transplant Program of the impending transplant; and
3. all transplant services must be rendered at a transplant Center of Excellence Transplant facility which participates in this program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from the employer or the Individualized Care Management (ICM) Managed Care Department.

If these requirements are not met, Special Transplant Program benefits may be reduced.

General Provisions

Early pre-certification to 1-888-4ORGANS must be made as soon as the covered person is identified as a potential transplant candidate. Once enrolled in the program, a Transplant Facilitator will be assigned and will coordinate the cost savings with the covered person and physician from hospital selection, to travel arrangements, to prescription drug options. The Transplant Facilitator will contact Individualized Care Management (ICM) Managed Care Department for benefit information, as well as contact the covered person's referring physician for additional information. Information about the program will be forwarded to the covered person regarding network hospitals and other relevant information. The Transplant Facilitator will work with the covered person, his or her physician and Individualized Care Management (ICM) to ensure quality and continuity of care throughout ther process, pre-transplant to post-transplant, including organ harvest.

Wellness Benefit

Eligible charges for the following routine services are covered as specified on the Schedule of Benefits: examinations, pap smears, mammograms, other related x-ray and laboratory services, immunizations and well-baby care. Also, included under this benefit: examinations for covered employees of the Plan required as a condition of employment that are paid for by the employer. The amount paid by the employer will apply toward the calendar year maximum specified by the Plan.

LIMITATIONS AND EXCLUSIONS OF THE MEDICAL PLAN

The following charges are not covered by the Plan. No medical benefits will be paid with respect to them, except as specified:

1. those due to an illness or injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
2. claims arising out of, or in any course of any occupation or employment for wage or profit or claims for which the covered person is entitled to benefits under any Workers' Compensation or occupational disease law, whether benefits are claimed or not;
3. charges or expenses for which the covered person (or the covered person's parent or guardian in the instance of a minor dependent) is not legally bound or obligated to pay or which are for medical care furnished without charge, paid for, or reimbursable by or through the government of a nation, state, province, county, municipality or other political subdivision, or instrumentality or agency of such government. This limitation will not apply where specifically prohibited by applicable statute;
4. those made by a Veteran's Administration hospital or a hospital operated by one of the Uniformed Services for a service related condition;
5. those made by a person, hospital, or entity normally making no charge for medical care, regardless of the patient's financial ability, if the patient has no insurance for medical care. This limitation will not apply where specifically prohibited by applicable statutes;
6. those made for radial keratotomy, routine eye care, eyeglasses, contact lenses, routine hearing checks, hearing aids or charges for the fitting of eyeglasses, contact lenses or hearing aids, other than the initial purchase of glasses or contacts for aphakia, keratoconus or following cataract surgery, nor does it apply to an initial hearing aid when a loss of hearing is a result of a surgical procedure. However, such expense will be considered a covered expense only to the extent of the least expensive service, supply or procedure which will correct the condition;
7. those made for personal comfort items including television and telephone;
8. charges for routine examinations, routine immunizations, routine x-ray and laboratory services and well-baby care, unless otherwise specified by the Plan;
9. charges for dental services, unless otherwise specified by the Plan;
10. charges in excess of the “Usual and Customary” fee as specified in the General Terms and Definitions and General Information sections of the Plan;
11. charges for services not medically necessary for diagnosis and treatment of an illness or injury;
12. services, supplies, human organ and tissue transplants, prescription drugs or medications which are Experimental or Investigational, unless otherwise specified by the Plan;

13. charges incurred outside of the United States for medical treatment, services, drugs or supplies on a date in excess of 30 days from the incurred date in a foreign location. No benefits shall be paid if the covered person traveled outside of the United States for the primary purpose of obtaining medical treatment, services, drugs, or supplies;

14. custodial care and rest cures;

15. treatment of an illness or injury resulting from the commission of, or attempt to commit by the covered person, a felony or aggravated battery, unless the injury or illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition);

16. charges in connection with cosmetic surgery or treatment, except those charges related to an accidental injury or charges for functional repair or restoration of any body part when necessary to achieve normal body function;

17. personal hygiene and convenience items;

18. charges incurred before the effective date or after the termination date of coverage;

19. failure to keep a scheduled visit, phone consultations, completion of claim forms or return to work or school forms;

20. services rendered by a family member, or a person who resides with the covered person;

21. purchase or rental of: exercise equipment, whirlpools, saunas, spas, swimming pools, electric beds, water beds, lift chairs, home elevator, air conditioners, purifiers, filters, commodes, grab bars, shower seating, cervical pillows, massagers or heel lifts;

22. treatment of infertility and fertility enhancements, including in vitro fertilization, artificial insemination or any other artificial means of conception, transsexual surgery or treatment, and treatment of sexual dysfunction not related to organic disease. Procedures designed to reverse elective or medically necessary sterilizations are not covered;

23. charges made by a hospital for a private room, unless otherwise specified by the Plan;

24. charges for smoking cessation, including deterrents;

25. charges for treatment of Temporomandibular Joint Dysfunction (TMJ), unless otherwise specified by the Plan;

26. charges for a grandchild of the employee unless the grandchild meets the definition of a dependent specified in the Plan;

27. charges in excess of any maximum benefit amounts specified on the Schedule of Benefits;

28. charges for room, board, and general nursing care for hospital admissions, mainly for physical therapy or for diagnostic studies;

29. charges for treatment to induce weight loss, unless it is determined to be medically necessary for treatment of morbid obesity;

30. charges for a pre-existing condition, as specified by the Plan;

31. charges for an abortion, except when the life of the dependent spouse or covered employee would be endangered if the fetus were carried to term, or the pregnancy is the result of rape or incest;

32. oral contraceptives and devices;

33. massage therapy, unless otherwise specified;

34. charges related to a dependent child maternity;

35. charges for dental implantology, dental braces;

36. marriage counseling;

37. charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;

38. charges for prescription drugs, medications or supplies except those which are administered in or dispensed at a physician's office, a hospital, skilled nursing facility or other inpatient setting. This exclusion does not apply to Interferon beta-1b (Betaseron) and Avonex. Betaseron and Avonex are covered as specified by the Plan;

39. charges for vocational training, including work hardening programs;

40. charges for corrective shoes;

41. charges by a provider or facility for Pre-admission Certification or Concurrent Stay Review;

42. charges for room and board incurred in connection with a hospital admittance from 8:00 a.m. Friday to 12:00 p.m. Sunday unless the attending physician states in writing it is due to Medical Necessity;

43. charges over the Usual and Customary as determined by IntraHealth Solutions, Inc. for medical records fees;

44. charges for third party examinations and treatments, such as those requested for employment, unless otherwise specified by the Plan; or purchase of insurance;

45. charges resulting from an intentional self-inflicted injury, unless the injury results from a medical condition (which includes a physical condition and/or a mental health condition);

46. charges for examinations and all related services which are performed pursuant to state statute or regulation, unless the injury or illness results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition);

47. charges incurred as the result of an injury sustained while participating in a non-sanctioned speed or endurance contest, auto racing or stunt driving, aerobatics, trapeze or high-wire demonstration or contests, hang-gliding, scuba diving except when the covered person is certified by a nationally recognized scuba diving training organization or under the instruction of one of their instructors; ski diving, or riding a three (3) wheel all terrain vehicle;

48. charges incurred for private duty nursing services, other than those performed for home health care services;

49. charges for acupuncture;

50. a response for information may be required by the Plan in order to process claims. The Plan has the right to deny claims submitted for benefit payment if such information is not received. (Please contact the Third Party Administrator if you have questions regarding the required information);

51. not a covered expense under the Plan;

52. charges for services not provided by a Physician/Provider are not covered under the Plan;

53. benefits under this Plan are limited to co-payments and/or deductibles not covered under an HMO, including eligible charges that are specifically excluded under the HMO. There will be no coverage under this Plan for any service, treatment or supply not covered by the HMO because the covered person chose to obtain such service, treatment or supply from a provider who is not an HMO participating provider, or because the covered person did not obtain a referral from the covered person's primary care physician, if such referral is required by the HMO; or

54. prosthetic devices and durable medical equipment which do not meet the requirements of items 1 through 4 in the definition “Medically Necessary” in the General Terms and Definitions section of the Plan.

PRESCRIPTION DRUG BENEFITS

Medco Health Solutions, Inc. will administer the Prescription Drug Plan. All prescription drug claims should be submitted directly to Medco for reimbursement.

Under this benefit, the covered person is responsible for the co-payment as specified on the Schedule of Benefits. After satisfaction of the listed co-payment, eligible charges are covered at 100%.

Eligible prescription drugs are as follows:

1. federal legend drugs;
2. compounded medication of which at least one ingredient is a prescription legend drug;
3. insulin;
4. diabetic supplies (i.e., insulin needles and syringes, test tape and chemstrips). Charges for other diabetic supplies may be covered under the Medical Plan;
5. legend and non-legend Meclizine on prescription;
6. legend smoking deterrents to a maximum of $550.00 while covered by the Plan;
7. vitamins when prescribed by a physician for females only through age 55;
8. prescribed drugs used for the treatment of ADD/ADHD;
9. oral, transdermal and intrauterine contraceptives (i.e. Nuva-Ring and Ortho-Evra patch);
10. Retin A, for non-cosmetic purposes;
11. Tamiflu, limited to a 34 day supply, or 8 units, whichever is less;
12. Relenza, limited to a 34-day supply, or 20 units, whichever is less; and
13. charges for injectable medications when prescribed by a physician.

The prescription drug benefit applies if the covered person has the prescription filled by a participating pharmacy. If the covered person is unable to locate a participating pharmacy, the prescription should be submitted directly to PAID Prescriptions, L.L.C. at the following address:

Medco
PO Box 2187
Lee's Summit, MO 64063-2187
(800) 455-6892

LIMITATIONS AND EXCLUSIONS OF THE PRESCRIPTION DRUG BENEFITS

The following charges are not covered and no benefit will be paid with respect to them, except as noted:

1. any prescription dispensed prior to the covered person's effective date or after the termination date of coverage;
2. charges for the administration or injection of any drug;
3. refills of covered drugs which exceed the number that the prescription order specifies or refills of covered drugs after one year from the date of the original prescription;
4. covered prescription drugs which are not customarily charged for, or for which the provider's charge is less than the required co-payment;
5. charges arising out of, or in the course of, any occupation or employment for wage or profit, or for which the covered person is entitled to benefits under any Workers' Compensation, Occupational Disease Law or similar laws, regardless of whether such policies are in force and regardless of whether benefits are claimed or not;
6. charges furnished or covered by, or on behalf of, the United States, or any state, province, or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance;
7. charges incurred for which the covered person is not, in the absence of this coverage, legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage;
8. covered prescription drugs or medicines covered by Medicare, if you are covered by or are eligible to be covered by either, Part A or B of Medicare, but only to the extent benefits are, or would be, available if you had applied for Medicare;
9. charges incurred due to an illness or injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
10. prescription drugs or medications which are Experimental or Investigational;
11. prescription drugs or medicines in connection with sex transformation surgery, including sex hormones related to such surgery;
12. prescription drugs or medicines for infertility, artificial insemination, in vitro or in vivo fertilization of an ovum, including Pergonal (Menotropins);
13. non-legend drugs, other than Insulin and Meclizine;
14. therapeutic devices or appliances, including support garments, and other non-medicinal substances, except those listed herein;
15. topical Minoxidil preparations, whether commercially prepared or compounded;
16. anorectic drugs, used for the treatment of obesity;

17. drugs used in the treatment of impotency;

18. all drugs which are not self-administered or are administered in a hospital, long-term care facility or other inpatient setting;

19. implantable contraceptives such as Norplant, regardless of intended use;

20. human growth hormones;

21. contraceptives, unless otherwise specified;

22. prescription drugs and medicines used in connection with, or for subsequent treatment of, transplants of body parts, tissues or substances, or implants of artificial or natural organs; or

23. charges for Interferon beta-1b (Betaseron) and Avonex.

COORDINATION OF BENEFITS

The Coordination of Benefits section is intended to determine which plan provides benefits when there are two or more plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, "Plan" means any plan providing medical or dental benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile "no-fault" and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; and (l) this Plan.

The term "Plan" is construed separately with respect to each Plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such Plan, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

"Allowable Expense" means any Usual and Customary fee, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

"Claim Determination Period" means calendar year, except that if in any calendar year the person is not covered under the Plan for the full calendar year, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

"Claim" means a request that benefits of a Plan be provided or paid.

"Primary Plan" means a Plan whose benefits are determined without regard to any other Plan.

"Secondary Plan" means a plan which is not a primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another Plan and may be reduced because of the other Plan's benefits.

For purposes of this Coordination of Benefits section, "This Plan" means the **City of Auburn** Medical and Prescription Drug Plan.

Effect on Benefits

Maintenance of Benefits: when a claim is made, the Primary Plan pays its benefits without regard to any other Plan. The Secondary Plan adjusts its benefits so that the total benefits

available do not exceed the Allowable Expense. No Plan pays more than it would without the coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other Plan does not have Coordination of Benefits, that Plan pays first.
2. The benefits of a Plan which covers the person as an employee, member, or subscriber (other than as a dependent) are determined before the benefits of a Plan which covers the person as a dependent.
3. **Birthday Rule:** the benefits of a Plan which covers the person as a dependent are determined according to which parent's birthdate occurs first in a calendar year (day and month). If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined first. If the other Plan does not contain the birthday rule but has a rule which coordinates benefits based on gender and the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the Order of Benefits.

   If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

   - when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be the Primary Plan;
   - when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody are determined before the benefits of the Plan which covers that child as a dependent of the stepparent. In addition, the benefits of a Plan which covers that child as a dependent of the stepparent are determined before the benefits of a Plan which covers that child as a dependent of the parent without custody; and
   - not withstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other Plan which covers the child as a dependent child.
4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a Plan which covers the person as a laid-off or retired employee, or as a dependent of such person, are determined after the benefits of a Plan which covers such person through his or her own present employment or through the present employment of another person.
5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a Plan which has covered the person for the longer period of time are

determined before the benefits of a Plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the covered person's consent, will release to, or obtain from, any insurance company, organization or person, information needed to implement this provision. The covered person shall agree to furnish any information required to apply these provisions.

Coordination of Benefits With Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If the covered person is eligible for Medicare Benefits, but not necessarily enrolled, the benefits under this Plan will be coordinated to the extent benefits would have been payable under Medicare, as allowed by Federal Statutes and Regulations.

Facility of Payment

Payment made under any other Plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

HOW TO FILE A CLAIM

The covered employee and covered spouse will receive a group benefits identification card. It will provide information such as the employee's name, group name and group number.

If a network provider is utilized, the network provider will file an itemized claim for you and payment will be made directly to the provider.

Whenever a covered person accesses health care services outside the network area, an itemized claim for those services may be filed by the provider and payment will generally be made directly to the provider.

If claim submission is not offered by the provider of service, then the covered person should refer to their identification card regarding the network(s) listed and ask the provider of service for the address of the network location for which the itemized claim can be submitted for processing. If the provider of service can not provide the network location address, then the covered person should contact the employer for network address information. Payment will be made directly to the provider, and only to the employee if proof of full payment is submitted. The covered person should not submit the provider's claim directly to IHS.

The covered person may choose any provider of service. There is no restriction on the selection of a provider as long as the provider of service meets the definitions contained in the Plan. Benefits are payable directly to the provider of service and only to the employee if proof of full payment is submitted. If IHS needs more information to process a claim, the covered person or the provider of service will be contacted.

An "itemized claim" must be submitted when filing a claim. An "itemized claim" is one which shows:

1. Employee's name, address and identification number.
2. Dependent's name, if the claim is on a dependent.
3. Employer's name.
4. Name and address of the provider of service.
5. Diagnosis.
6. Itemization of charges.
7. Date the illness or injury began or the date treatment started.

Canceled checks, cash register receipts or personally prepared claims are not accepted in lieu of itemized claims from providers of service.

If benefits are subject to the Coordination of Benefits provision, whereby another plan is required to pay benefits first, a copy of the other plan's Explanation of Benefits should be sent to IHS. This can be done either when initially submitting the claim or as soon as possible thereafter. This procedure will expedite the processing of claims subject to the Coordination of Benefits provision.

GENERAL TERMS AND DEFINITIONS

"ACTIVELY AT WORK" means that the employee is at work and performing the regular duties of the employee's position for the employer.

An employee is considered to be actively at work for the employer on: (a) each day of regular paid vacation; (b) each regular non-working day, provided in each instance that the employee was actively at work on the last regular work day preceding the absence; (c) any day an employee is covered under the Plan by virtue of a leave as described in the Plan (other than an FMLA leave); (d) any day an employee is on an FMLA leave; or (e) for purposes of the waiting period to obtain coverage under the Plan as specified in the "Effective Date of Coverage" provision in the Effective Date of Coverage section of the Plan, any day on which an employee is absent from employment with the employer due to a health factor of the employee.

"AMBULATORY SURGICAL CENTER" means a licensed facility that provides general surgery and meets all of the following requirements:

1. is directed by a staff of physicians, at least one of whom must be on the premises when surgery is performed and during the recovery period;
2. has at least one certified anesthesiologist at the site when surgery which requires general or spinal anesthesia is performed and during the recovery period;
3. extends surgical staff privileges to physicians who practice surgery;
4. has at least two operating rooms and one recovery room;
5. provides, or coordinates with a medical facility in the area for, diagnostic x-ray and laboratory services needed in connection with surgery;
6. provides in the operating and recovery rooms full-time skilled nursing services directed by a registered nurse; and
7. is equipped and has trained staff to handle medical emergencies. It must have a: (a) physician trained in cardiopulmonary resuscitation; (b) defibrillator; (c) tracheotomy set; and (d) blood volume expander.

"CALENDAR YEAR" means the period from January 1 through December 31 of the same year.

"CARDIAC PATHWAYS PROGRAM" means the cardiac benefits offered by Parkview Memorial Hospital which provides enhanced benefits for the following procedures: Valve (without Cath), CAB (with or without Cardiac Cath), PTCA (with or without Cardiac Cath) and inpatient and outpatient Cardiac Cath.

"CONFINEMENT" means the period of time in which a covered person is registered as an inpatient for which a room and board charge is made. Confinement begins with admission and ends with discharge.

"COVERED PERSON" means a person meeting the eligibility requirements for coverage as specified in the Plan, who has satisfied any applicable waiting period and who is properly enrolled in the Plan.

"CUSTODIAL CARE" means care designed to help a person in the activities of daily living, and which does not require the continuous attention of trained medical or paramedical personnel. Such care may involve preparation of special diets, supervision of medication that can be self-administered and assistance in getting in or out of bed, walking, bathing, dressing and eating.

"DEPENDENT" means:

1. a lawful spouse of the covered employee who is a resident in the same country in which the covered employee resides, with the exception of a spouse who is eligible for medical expense insurance or becomes eligible under a plan sponsored by his/her employer (whether the spouse is currently covered or previously declined coverage under that plan). (A lawful spouse of a covered employee is an individual of the opposite sex of the covered employee who has met all of the requirements of a valid marriage to the covered employee in the state where the marriage was performed. A lawful spouse shall not include a domestic partner); a spouse who is eligible for medical expense insurance or becomes eligible under a plan sponsored by his/her employer (whether the spouse is currently covered or previously declined coverage under that plan);

2. each unmarried Child (as defined in subparagraphs a-e below) of the covered employee who is less than age 19 or who is at least age 19 but less than age 23 and meets the requirements of the "Full-time Student" provision as specified in the Eligibility for Coverage section of the Plan. Unless otherwise required by court order or divorce decree, the covered employee must provide more than one-half of the Child's support for the calendar year, unless otherwise required by a Qualified Medical Child Support Order ("QMCSO"). "Child" shall mean:

(a) a natural born son or daughter of the covered employee;

(b) a child for whom the covered employee has been appointed guardian by court order or a stepchild, provided the employee meets the support and maintenance requirements for the stepchild or ward as specified above and provided the stepchild or ward has not attained the limiting age requirements as specified above;

(c) a child who meets the requirements of the Handicapped Child provision as specified in the Eligibility for Coverage section of the Plan;

(d) a child who meets the requirements of the Adopted Child provision as specified in the Eligibility for Coverage section of the Plan; or

(e) a child who meets the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order as specified in the Eligibility for Coverage section of the Plan.

"EFFECTIVE DATE OF COVERAGE" means the date on which coverage under the Plan begins for a covered person, provided application for coverage was made when eligible for coverage under the Plan.

"EFFECTIVE DATE OF THE PLAN" means July 1, 2003.

"EMPLOYEE" means a full-time employee (hourly or salaried) actively at work and working 40 or more hours per week on a regular basis for the employer.

An employee, for purposes of this Plan shall not include a temporary, part-time, seasonal, independent contractor, or leased (even if determined to be a common-law employee) employee or a retired employee except as specified in the ""Retired Employee Coverage Continuation" provision as such classifications are determined by the employer in its sole discretion and/or as such classification may be reflected on the payroll records of the employer. Any classification, reclassification or other characterization of any such individual as an employee of the employer, whether as a statutory, common law employee or otherwise, by a court of law or by action of any federal, state or local governmental agency shall be of no affect on the exclusion of such individual from participation in the Plan. Any individual whom the Plan Administrator determines is not an employee shall not be treated as an employee hereunder solely because he has been classified or reclassified as an employee of the employer by any court or government agency.

"EMPLOYER" means **City of Auburn.**

"EXPERIMENTAL OR INVESTIGATIONAL" means any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. the device, drug or medicine 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 device, drug or medicine is furnished;
2. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis;
3. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

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

or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigational shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of non-human organs, tissues, or cells.

"FAMILY MEMBER" means a covered person's spouse, child, parent, brother, sister and any other eligible dependent as described by the Plan.

"HOME HEALTH CARE" means services or supplies rendered to, and in the home of, a covered person or in the home of a family member as an alternative to services and supplies provided as part of an inpatient confinement in a hospital or skilled nursing facility.

"HOME HEALTH AIDE SERVICES" means those services which may be provided by a qualified individual, other than a registered nurse, which are medically necessary for the care and treatment of a covered person.

"HOME HEALTH CARE AGENCY" means an agency which: (a) is certified by the covered person's physician as an appropriate provider of home health aide services; (b) has a full-time administrator; (c) maintains daily clinical records of services provided to the covered person; (d) includes on its staff at least one registered nurse to supervise nursing care; and (e) is coordinated by a state licensed Medicare certified home health care agency or certified rehabilitation agency.

"HOME HEALTH CARE PLAN" means care and treatment of a covered person for an injury or illness under a plan of home care established and approved in writing by the covered person's attending physician. The physician must also certify that the treatment for the injury or illness would otherwise require confinement in a hospital or a skilled nursing facility. The home health care plan must be reviewed at least every two months.

"HOSPITAL" means an institution which is duly licensed as a hospital (to the extent such licensing is required by state or federal law) and which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis and which meets all of the following requirements:

1. is an institution accredited by the Joint Commission on Accreditation of Hospitals or is a hospital that is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare;
2. provides organized facilities for laboratory, diagnostic services, medical treatment and surgery;
3. provides 24-hour nursing care by licensed registered nurses;
4. has a staff of one or more licensed physicians available at all times; and
5. in no event, however, shall the term hospital include an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility or a home for the aged.

To the extent that benefits are provided, a facility approved under the laws of the state of its jurisdiction, for the treatment of mental health and substance abuse will be considered a hospital under this Plan, with respect to benefits for such treatment.

"ILLNESS" means pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

"INJURY" means a condition caused by accidental means and from an external force which results in damage to the covered person's body from an external force.

"INTENSIVE CARE UNIT OR CORONARY CARE FACILITY" means a section, ward, or wing within a hospital, which is operated solely for critically ill patients. It provides special supplies, equipment and constant observation and care by registered nurses or other hospital personnel.

"LATE ENROLLEE" means an individual who enrolls for coverage under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan, or
2. a special enrollment period. [See "Special Enrollment Provisions" in the Effective Date of Coverage section of the Plan.]

"MASTER PLAN DOCUMENT" means that document signed by the Plan Sponsor and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto which set forth the terms of the Plan.

"MAXIMUM BENEFIT" means the total eligible charges that the Plan will pay per covered person while that covered person is covered by the Plan.

"MEDICALLY NECESSARY" means that a service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider is required to diagnose or treat a covered person's illness or injury and which is, as determined by the Plan Administrator: (1) consistent with the symptoms or diagnosis and treatment of the covered person's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the covered person, physician, hospital or other health care provider; and (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the covered person and accomplishes the desired end result in the most economical manner. However, the fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply medically necessary.

"MEDICARE" means the program for health benefits under Title XVIII of the Social Security Act as amended.

"MENTAL HEALTH" means mental, nervous or emotional disease or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of

the original cause of the disorder. (Note: Substance Abuse shall not be deemed a Mental Health condition for purposes of this Plan.)

"PHYSICIAN/PROVIDER" means any person who is validly licensed to perform services for which benefits are provided under the Plan and who is acting within the scope of that license. For purposes of Mental Health and Substance Abuse charges, "Physician/Provider" shall also include any person approved or licensed by the state in which services are rendered for treatment of such conditions.

"PLAN" means this employer's Master Plan Document and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto.

"PLAN ADMINISTRATOR" means **City of Auburn.**

"PLAN SPONSOR" means **City of Auburn.**

"PLAN YEAR" means the period beginning July 1st and ending June 30th.

"SERVICE IN THE UNIFORMED SERVICES" means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

"SKILLED NURSING FACILITY" means a facility which meets the following:

1. is regularly engaged in providing skilled nursing care for sick and injured persons;
2. requires that the patient be regularly attended by a physician;
3. maintains a daily record of each patient;
4. provides 24-hour nursing care which is supervised by a registered nurse;
5. is not, except incidentally, a home for the aged, a hotel or the like;
6. is not, except incidentally, a place for the treatment of mental health and substance abuse; and
7. is licensed as a skilled nursing facility, if such licensing is required.

"SUBSTANCE ABUSE" means the use of a psychoactive substance in a manner detrimental to society or the covered person and which meets, or with continued use may meet, criteria for substance abuse or drug dependency.

"THIRD PARTY ADMINISTRATOR" means **IntraHealth Solutions, Inc. (IHS)**.

"UNIFORMED SERVICES" means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

"USUAL AND CUSTOMARY" means the fee usually and customarily accepted as payment for the same services within a geographical area in which the physician practices as determined by the Third Party Administrator.

In the case of a PPO Provider, Usual and Customary is the negotiated PPO discount rate for the service or procedure.

"WAITING PERIOD" means the period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of IntraHealth Solutions, Inc. (IHS) as Third Party Administrator. IHS provides administrative claim payment services only and does not assume any financial risk or obligation with respect to claims. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the company identified in the Plan Information section as the Agent for Service of Legal Process. The employer may delegate any of its powers or responsibilities among its employees and to such other agents as the employer deems appropriate.

Benefit Claim Procedures and Appeal Procedures for Claims

Appeals (other than appeals of Urgent Care claim determinations) must be made in writing to the attention of the "Appeal Department" at the address listed below.

Urgent Care claims and appeals of Urgent Care claim determinations can be made in writing to the address listed below or, during IHS's normal business hours, by fax or telephone at the numbers listed below.

IntraHealth Solutions, Inc.
111 E Ludwig Road, Ste 108
Fort Wayne, IN 46825

Telephone Number: 1-877-755-4010

Fax Number: (260) 969-4011

Procedures Upon Initial Filing of a Claim

The following procedures apply to an initial filing of a claim with the Plan:

Time Limits on Decisions: The time frame for processing the covered person's initial claim depends on the type of claim it is: urgent care, concurrent care, pre-service or post-service. The covered person's claim will be processed according to the highest priority category that applies to it.

1. **Urgent Care Claims:** If a covered person's claim is an urgent care claim for which the Plan requires pre-certification, the Plan will notify the covered person as soon as possible, taking into account the medical exigencies. A determination will be sent to the covered person no later than 72 hours after the Plan's receipt of the covered person's claim.

   If the covered person fails to provide sufficient information to allow the Plan to make its determination, the Plan will notify the covered person as soon as possible, but not later than 24 hours after the Plan receives the covered person's claim. The covered person will have a reasonable period of time (not less than 48 hours) to respond and provide the

additional information. After the Plan receives this additional information, the Plan will notify the covered person as soon as possible whether his or her benefit claim has been granted or denied. This notification will occur no later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information; or (2) the end of the period granting the covered person additional time to provide the additional information.

An urgent care claim is any claim for medical care or treatment where using the non-urgent care claim time-frames:

a) Could seriously jeopardize the covered person's life or health or ability to regain maximum function; or

b) Would, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. **Concurrent Care Conditions:** If the covered person is currently receiving ongoing treatment or the treatment is going to be provided over a number of sessions, special rules apply:

a) Any notice of reduction or termination (except by Plan amendment or termination) will be given to the covered person by the Plan at a time sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review before the benefit is reduced or terminated.

b) Any request made by the covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, will be decided by the Plan as soon as possible taking into account medical exigencies. Notice to the covered person will be made within 24 hours after the Plan receives the request, as long as the Plan receives his or her claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. **Pre-Service Claim:** For a pre-service claim, the Plan will notify the covered person of the decision within a reasonable period of time appropriate to the medical circumstances. This notification will be made no later than 15 days after the Plan receives the covered person's claim.

The 15-day period may be extended for an additional 15 days if:

a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and

b) The Plan notifies the covered person, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

c) If the 15-day extension is necessary because the covered person failed to submit the information necessary to decide the claim, the Plan will provide notice to the covered person of this 15-day extension and will describe the required information necessary to decide the claim. The covered person will have at least 45 days from receipt of this notice to provide the requested information.

A pre-service claim means any claim for a benefit under the Plan where the Plan conditions receipt of the benefit (in whole or in part) on approval of the benefit in advance of obtaining medical care.

4. **Post-Service Claim:** For a post-service claim, the Plan will notify the covered person of the decision within a reasonable period of time. This notification will be made not later than 30 days after receipt of the claim by the Plan.

   The 30-day period may be extended for an additional 15 days if:

   a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and

   b) The Plan notifies the covered person, prior to the end of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

   c) If the 15-day extension is necessary because the covered person failed to submit the information necessary to decide the claim, the Plan will provide notice to the covered person of this 15-day extension and will describe the required information necessary to decide the claim. The covered person will have at least 45 days from receipt of this notice to provide the requested information.

   A post-service claim is any claim under the Plan that does not satisfy the definitions of the other types of claims.

Failing to Follow the Plan's Procedures for Filing a Claim: If the covered person fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the covered person as soon as possible, but not later than five days after the failure (24 hours if the failure involved urgent care). This notification can be oral, unless the covered person requests that it be in writing.

Manner and Content of Notification of Benefit Determination
If the Plan denies the covered person's claim for benefits, the Plan will provide the covered person with a written or electronic notification of this determination.

Appeal of Adverse Benefit Determination
If the Plan issued an adverse benefit determination on a claim submitted by the covered person, the covered person has a right to appeal the adverse benefit determination to a named fiduciary of the Plan. This review will:

1. Provide the covered person with the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

2. Provide that the covered person will be provided, upon request and free of charge, reasonable access to, or any copies of, all documents, records and other information relevant to his or her claim for benefits;

3. Take into account all comments, documents, records and other information submitted by the covered person relevant to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

4. Provide that the covered person has at least 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 90 days following receipt of the first appeal determination to request a final appeal;

5. Not afford deference to the initial adverse benefit determination and provide that the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

6. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, an appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

7. Identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the covered person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

8. Provide that the health care professional who provides consulting services will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination nor the subordinate of any such individual;

9. Provide, in the case of a claim involving urgent care, 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 covered person; and

b) All necessary information, including the Plan’s benefit determination on review, will be transmitted between the Plan and the covered person by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review
If the covered person appeals an adverse benefit determination, the Plan will respond to his or her appeal within certain time limits:

1. **Urgent Care Claims.** In the case of a claim involving urgent care for which the Plan requires pre-certification, the Plan will notify the covered person of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the covered person's request for review of an adverse benefit determination.

2. **Pre-Service Claims.** For pre-service claims, the Plan will notify the covered person of the decision within a reasonable period of time appropriate to the medical circumstances. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 15 days after the Plan receives the covered person's request for review of an adverse benefit determination.

3. **Post-Service Claims.** For post-service claims, the Plan will notify the covered person of the decision within a reasonable period of time. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 30 days after the Plan receives the covered person's request for review of an adverse benefit determination.

Manner and Content of Notification of Benefit Determination on Review
The Plan will provide the covered person with written or electronic notification of the Plan's benefit determination and review.

The Plan Sponsor will have the sole discretion to make the determination of all final appeals. First appeals will be determined by the Third Party Administrator or its designee. Benefits under the Plan will be paid only if the Plan Sponsor (or its designee) decides in its full and absolute discretion that the covered person is entitled to such benefits.

If any time limitation stated in this section is less than that required by law, the limitation is extended to agree with the minimum period permitted by law.

The Plan will not be liable for any benefits after the date the Plan has terminated.

If the Plan provides Short Term Disability Benefits, then please refer to the Short Term Disability Benefits section of the Plan for information regarding Short Term Disability Benefits claim appeal procedures.

Calculation of Plan Maximum Amounts

Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Clerical Error

Clerical error on the part of the Plan Administrator or Third Party Administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by the Third Party Administrator. The covered person agrees to reimburse the Plan for any payment made to or for the covered person in error.

Common Accident Deductible

If two or more members of the same family are injured in a common accident, only one deductible amount, if applicable, will be applied.

Conformity With Government Law

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

Cost Sharing Provisions

Typically, these terms are used in the "Schedule of Benefits" section of the Plan. The Plan may use one or more of these terms.

"Deductible" generally means an amount which is reduced from eligible charges before benefits of the Plan are payable. It is the covered person's responsibility to pay the deductible amount.

"Coinsurance" generally means the percentage of the eligible charges for covered services and supplies which the Plan will pay —subject to all of the provisions of the Plan. It is the responsibility of the covered person to pay for the percentage of coinsurance not payable by the Plan.

"Copayment" generally means a fixed amount of money that a covered person is required to pay toward the cost of a specified service or supply that is covered by the Plan.

"Non-compliance Penalty" generally means an amount that is reduced from eligible charges due to a failure to comply with specified provision requirements of the Plan. Any amount not covered by the Plan due to a non-compliance penalty is the responsibility of the covered person.

The covered person will also be responsible to pay for charges that the Plan will not cover such as those that exceed the Usual and Customary amount covered by the Plan for a service or supply, charges for amounts that relate to services or supplies that are not covered by the Plan and charges for amounts that exceed the Plan's benefit maximums or plan maximums.

Deductible Carry Over

If a covered person incurs eligible charges during the period beginning October 1 through December 31 which are applied to the deductible for that calendar year, these charges are also applied toward satisfaction of the deductible for the next following calendar year.

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service, HMO or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

Master Plan Document

The Master Plan Document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan.

Medical Care Provided By The United States

The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related illness or injury. The Plan will also reimburse eligible charges for medical care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between “new” drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Newborns’ and Mothers’ Health Protection Act Notice

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). Maternity stays exceeding either the 48 hour or 96 hour period, require certification by the Individualized Care Management (ICM) Managed Care Department or benefits may not be payable for the remainder of the hospital stay.

Participant Contribution

A Participant Contribution is the amount an employee is required to pay in order to participate in the Plan. Contact your employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage (COBRA)" will receive a separate notice which will indicate the cost to participate in the Plan.

Payments Directly To Providers

The Plan shall pay a provider directly for health services rendered by such provider to a covered person, unless otherwise specified by the employee.

Physical Examination

The Plan at its expense shall have the right and opportunity to have the covered person examined for evaluation and verification of an illness or injury as often as it may be required during the pending of a claim.

Plan Amendment or Termination

While the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. The Board of Directors of the Plan Sponsor either will have pre-approved or will later ratify by corporate resolution, including by general ratification, any such Plan amendment or termination of the Plan.

In the event the Plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms and conditions of the Plan. Plan assets will be allocated first to the payment of claims, and thereafter in a manner that is for the exclusive benefit of the participants, except that any taxes and administration expenses may be made from Plan assets.

Plan Interpretation

The Plan Administrator shall have all powers necessary to effectuate the provisions of the Plan. The Plan Administrator has contracted with Total Claims Solution to process claims, maintain Plan data, and perform other Plan connected services. However, the Plan Administrator shall determine all questions arising in the administration, interpretation and application of the Plan, and shall, from time to time, formulate and issue such rules and regulations as may be necessary for the purpose of administering the Plan. Any interpretation, determination, rule, regulation, or similar action or decision issued by the Plan Administrator, or any person acting at its direction, shall be conclusive and binding on all persons, except as otherwise provided herein with any such determination, rule, regulation or similar decision not being set aside by a reviewing tribunal unless it is determined by a court of competent jurisdiction that the Plan Administrator acted in an arbitrary and capricious manner. Benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between the employer and any employees or other persons or to be a consideration for, or an inducement or condition of, the employment of any 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 or abridge the right of, the employer to discharge any employee at anytime.

Plan Maximums and Benefit Maximums

"Plan Maximums" generally means the total amount the Plan will pay for any covered person while he or she is a participant in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

"Benefit Maximums" generally means the Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an illness or injury. These limitations may also be expressed in other terms, for example, a number of days, visits or confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Plan's Rights to Subrogation and Reimbursement

If a covered person incurs medical, dental, prescription drug or disability expenses for an illness or injury because of the fault, in whole or in part, of another person, that other person may be legally responsible for those medical, dental, prescription drug or disability expenses. Furthermore, a covered person or the covered person's guardian or estate may be entitled to receive money from an insurance contract for medical, dental, prescription drug or disability expenses resulting from an injury or illness. The Plan will be subrogated to all rights of recovery the covered person or the covered person's guardian or estate may have against such other person or persons and such insurance contract or contracts for medical, dental, prescription drugs or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person or the covered person's guardian or estate.

The Plan shall have the right to receive payment or repayment of those expenses referred to above from the person or persons that caused the illness or injury, any person who has legal responsibility for that person, that person's liability insurer, or any other insurer providing coverage for that person. The Plan shall also have the right to recover expenses it has paid or is obligated to pay from amounts paid for those expenses referred to above from the covered person's or his or her guardian's or estate's auto insurance including but not limited to uninsured or underinsured motorist coverage and med pay.

The Plan shall have "dollar one" recovery entitlement from any amounts **paid** and not simply from amounts received, regardless of whether the covered person or his or her guardian or estate is "made whole".

The Plan is automatically assigned the covered person's or the covered person's guardian's or estate's right of recovery against third parties (including their insurers) who are responsible in whole or in part for causing the injury or illness, to the extent of amounts the Plan has paid or is legally obligated to pay for the medical, dental, prescription drug or disability expenses of the covered person. The Plan will be entitled, but not obligated, to proceed in the name of the covered person or the covered person's guardian or estate against the person or persons responsible to repay the Plan for expenses the Plan has incurred for the covered person as identified above, if the covered person or the covered person's guardian or estate fails to take the necessary action to recover such expenses.

The amount of the Plan's subrogation claim must be included in any litigation filed or any claim made or asserted by or for the covered person or the covered person's guardian or estate in connection with the injury or illness giving rise to the expenses referred to above including claims made against the covered person's own insurance. When the claim is settled or any amount is paid to the covered person, his or her legal representative, or guardian, or estate then

the person receiving such funds must reimburse the Plan or cause the Plan to be reimbursed for medical, dental, prescription drug or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person.

The covered person or the covered person's guardian or estate shall not prejudice the Plan's rights of subrogation and reimbursement and shall sign and deliver documents to evidence or to secure those rights to the Plan. The Plan has the right to receive from the covered person or the covered person's guardian or estate, prior to the Plan's payment of claims or at any time subsequent thereto, a completed subrogation questionnaire, a reimbursement agreement and an acknowledgment of the Plan's subrogation and recovery rights signed by the covered person or the covered person's guardian or estate, or his or her authorized legal representative, on forms provided by the Plan.

The covered person, or the covered person's guardian, or estate is not authorized to obtain legal representation, to act on behalf of the Plan for recovery of any amounts paid by the Plan. Any contingent fee or retainer agreement entered into by the covered person or the covered person's guardian or estate will have no effect on the Plan's entitlement to the full amount of its subrogation claim on a "dollar one, first priority basis", regardless of any asserted offset for attorney fees or costs or other reduction unless specifically agreed to in writing by the Plan. This also applies to any other similar federal or state common law which would cause the Plan to receive less than the full amount of its claim. The concept of the "common fund doctrine" that governs the allocation of attorney's fees does not apply to this Plan or its rights to subrogation and recovery. The Plan may, at its discretion, enter into an agreement with the covered person his or her legal representative, guardian, or estate to represent its subrogation interest.
The Plan's rights as provided in this "Plan's Rights to Subrogation and Reimbursement" provision of the Plan document are created and preserved regardless of whether the covered person or the covered person's guardian or estate is "made whole", signs a reimbursement agreement, or signs an acknowledgment of the Plan's subrogation and recovery rights. The covered person, the covered person's guardian, estate, or legal representative shall make no distributions nor authorize any distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien or the expenses for medical, dental, prescription drug, or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person without the written approval of the Plan and shall not release any party or their insurer without the prior written approval of the Plan. In addition, the covered person, his or her guardian, estate, or legal representative will not withhold or intercept any amounts due the Plan from any party. Additionally, the covered person, his or her guardian, estate, or legal representative shall not instruct any party to forward amounts owed to the Plan, to any entity other than the Plan, in the absence of a prior written agreement with the Plan or its Third Party Administrator.

The subrogation rights of the Plan shall be superior to and the Plan shall have "first priority" over any competing claims of the covered person, his or her guardian, estate, or legal representative, or any competing claims of a parent, spouse, or child of a covered person, to any designated or undesignated proceeds of a judgment, award, or insurance settlement of the claims of the covered person, or of any other person where such settlement, judgment or award relates to or arises from the circumstances giving rise to the medical, dental, prescription drug or disability expenses of

the covered person that the Plan has paid or that the Plan is legally obligated to pay to or on behalf of the covered person.

A covered person also includes any dependent of the covered person where applicable.

Presumption of Receipt of Information

It shall be presumed that any information, notification or decision, provided by the Plan through the U.S. Mail, to a covered person or provider located in the United States is received by the covered person or provider within three (3) days of the date of mailing.

Preventive Services

The Plan provides information on coverage provided or excluded by the Plan for preventive health benefits or wellness benefits. This information is located in the Schedule of Benefits, Comprehensive Medical Benefits or Limitations and Exclusions of the Medical Plan sections of the Plan. As is the case with all benefits of the Plan, these services are subject to all the provisions of the Plan including, the limitation that such services not be "Experimental or Investigational".

Privacy and Security of Protected Health Information

1. Plan Sponsor's Certification of Compliance.

Neither the Plan nor any business associate servicing the Plan will disclose Plan Participants' Protected Health Information, including any Electronic Protected Health Information, as defined by 45 Code of Federal Regulations (CFR) §160.103, to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Document has been amended to incorporate this section and agrees to abide by this section.

2. Purpose of Disclosure to Plan Sponsor.

a) The Plan and any business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by the Plan Sponsor of Plan Participants' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this section.

b) Neither the Plan nor any business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor unless the disclosures are explained in the Privacy Practices Notice distributed to the Plan Participants.

c) Neither the Plan nor any business associate servicing the Plan will disclose Plan Participants' Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

3. Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information.

a) The Plan Sponsor will neither use nor further disclose Plan Participants' Protected Health Information, except as permitted or required by the Plan Document, as amended, or as required by law.

b) The Plan Sponsor will ensure that any agent, including any subcontractor, to which it provides Plan Participants' Protected Health Information agrees to the restrictions and conditions of the Plan Document, including this section, with respect to Plan Participants' Protected Health Information, including implementation of reasonable and appropriate security measures to protect such Protected Health Information in accordance with 45 CFR §164.314(b)(2)(iii).

c) The Plan Sponsor will not use or disclose Plan Participants' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

d) The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure. Additionally, pursuant to 45 CFR §164.314(b)(2)(iv), the Plan Sponsor will report to the Plan any security incident of which it becomes aware, under the following conditions. If a security incident results in an actual disclosure of Protected Health Information not permitted herein, the Plan Sponsor will report such incident to the Plan. The Plan Sponsor will report to the Plan any unauthorized: (1) access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware; or (2) interference with system operations in the Plan Sponsor's information systems, involving the Plan's Electronic Protected Health Information of which the Plan Sponsor becomes aware.

e) The Plan Sponsor will make Protected Health Information available to the Plan or to the Plan Participant who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

f) The Plan Sponsor will make Plan Participants' Protected Health Information available for amendment, and will on notice amend Plan Participants' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

g) The Plan Sponsor will track disclosures it may make of Plan Participants' Protected Health Information that are accountable under 45 Code of Federal Regulations § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

h) The Plan Sponsor will make its internal practices, books, and records relating to its use and disclosure of Plan Participants' Protected Health Information available to the Plan and to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Part 164, Subpart E "Privacy of Individually Identifiable Health Information."

i) The Plan Sponsor will, if feasible, return or destroy (and cause its subcontractors and agents to, if feasible, return or destroy) all Plan Participant Protected Health Information, in whatever form or medium, received from the Plan or any business associate servicing

the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Participant who is the subject of the Protected Health Information, when the Plan Participants' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant Protected Health Information, the Plan Sponsor will limit (and will cause its subcontractors and agents to limit) the use or disclosure of any Plan Participant Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

4. Adequate Separation Between the Plan Sponsor and the Plan.

The following employees or classes of employees or other workforce members under the control of the Plan Sponsor may be given access to Plan Participants' Protected Health Information received from the Plan or a business associate servicing the Plan:

Clerk Treasurer	Deputy Clerk - Treasurer

This list includes every employee or class of employees or other workforce members under the control of the Plan Sponsor who may receive Plan Participants' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

The employees, classes of employees or other workforce members identified above will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' Protected Health Information in breach or violation of or noncompliance with the provisions of this section. Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, as required by paragraph 3(d) of this section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Participant, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance. The Plan Sponsor will ensure that access to Protected Health Information of the employees, or classes of employees identified above, is supported by reasonable and appropriate security measures, in accordance with 45 CFR §164.314(b)(2)(ii).

5. Safeguard Requirement.

Pursuant to 45 CFR §164.314(b)(2)(i), the Plan Sponsor will implement administrative, physical, and technical safeguards to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

Proof of Claim

Written proof of a claim must be submitted to the Plan by the covered person or the provider of service within six months after the date such claim is incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to provide written proof of the claim within the time required, except that no claim shall

be eligible for payment if it is submitted more than 12 months from the date the claim was incurred. A claim shall be considered as incurred on the date the services or supplies are rendered or received.

Rescission of Coverage

The Plan has the right to rescind coverage for which the employee or covered person made a material misrepresentation on his or her application for coverage form or change notice form. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the employee or a covered person or cover a medical condition of the employee or a covered person when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the employee, covered person or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Right of Recovery For Payments Made

The Plan reserves the right to recover payments made under the Plan in the amount by which the payments exceed the maximum amount required to be paid under the provisions of the Coordination of Benefits section or any other provisions of the Plan. In the discretion of the Plan Administrator, such recovery may include the reduction in the payment by the Plan of the future benefits properly payable under the Plan. This right of recovery applies against:

1. any person to whom, for whom, or with respect to whom such payments were made; or
2. any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

Rights With Respect To Medicaid

Payment of benefits with respect to a covered person under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such covered person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a covered person in the Plan or in determining or making any payments for benefits of an individual as a covered person, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a covered person in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a covered person for payment for such supplies, services or treatments.

Self-funding

This is a self-funded Plan which means claims are paid directly by the Plan Administrator from its assets. The Plan Administrator has entered into a legal arrangement with a Third Party Administrator to assure accurate, impartial and timely payment of benefits to, and on behalf of, covered employees and their covered dependents.

Summary Plan Descriptions

The employer will issue to each covered employee or dependent, COBRA participant and retired employee (if retired employees are covered under the Plan), a Summary Plan Description which summarizes the benefits to which the covered person is entitled.

Use of Network or PPO Providers

Preferred Provider Organizations are referred to in the Plan as PPOs and medical providers within those PPOs are referred to as network providers or PPO providers. The section of the Plan entitled "Information Regarding PPO and Non-PPO Providers" provides general information regarding the use of PPO providers. In addition, the Schedule of Benefits section of the Plan indicates how benefits of the Plan will be determined, depending on whether and how the participant uses a PPO provider. Generally, a covered person will receive a greater benefit under the Plan if he or she elects to use the services of a PPO provider and may receive a lesser benefit if he or she elects to use a Non-PPO provider. If the distinction between PPO and Non-PPO providers is applicable to the Plan, then the Schedule of Benefits provides information which describes the instances for which a covered person may receive the PPO level of benefits, even though a Non-PPO provider is used.

The Appendix to this Plan entitled "Composition of the Network/PPO Network" provides information regarding the network or PPO network. The Plan Sponsor reserves the right to change networks, PPOs and the information contained in the Appendix "Composition of the Network/PPO Network" at any time.

A separate description of the network and a listing of PPO network providers can be obtained automatically, without charge, from the employer or Third Party Administrator.

Usual and Customary Procedure

IHS will cover the amount which is usually and customarily charged for that type of service. The amount in excess of the usual and customary fee may be pended for additional information. The employee will be notified on the Explanation of Benefits or by letter that IHS is requesting additional information. IHS will then contact the provider, which will give the provider the opportunity to supply IHS with additional information which may explain the higher fee. This may include an operative report or medical records if signed authorization is received from the employee. If after receiving the additional information, the higher amount cannot be justified, IHS will outline the reasons for the denial.

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any injury or illness occurring during, or arising from, the employee's course of employment.

PLAN INFORMATION

EMPLOYER, PLAN ADMINISTRATOR AND NAMED FIDUCIARY:

City of Auburn
210 East 9th Street
Auburn, IN 46706
(262) 925-6450

EMPLOYER IDENTIFICATION NUMBER:

35-6000943

PLAN NUMBER:

501

THE FOLLOWING COVERAGE IS INCLUDED IN THIS PLAN:

Comprehensive Medical and Prescription Drug Benefits

TYPE OF ADMINISTRATION:

Self-Funded Group Health Plan

THIRD PARTY ADMINISTRATOR:

IntraHealth Solutions, Inc.
111 E Ludwig Road, Ste 108
Fort Wayne, IN 46825
1-877-755-4010

AGENT FOR SERVICE OF LEGAL PROCESS:

City of Auburn Medical and Prescription Drug Plan
c/o IntraHealth Solutions, Inc.
111 E Ludwig Road, Ste 108
Fort Wayne, IN 46825
1-877-755-4010

COST:

The contributions necessary to finance the Plan are shared by the employer and the employee.

FINANCIAL RECORDS:

The financial records of the Plan are kept on a Plan Year basis ending on each June 30th.

Preferred Provider Organization (PPO) Questionnaire

To Be Attached To Employer Sponsored Group Health Plan

General Information

Complete PPO Name: American Caresource Holdings, Inc

Complete PPO Address: 8080 Tristar Drive, Suite 100, Irving. TX 75063

PPO Phone Number: 800-370-5994 **PPO Fax Number:** 972-871-8632

PPO Web Site Address: americancaresource.com

PPO Customer Service Contact / Title: Tonya Fenimore/Client Services Manager

Please Specify the Date this PPO was Established: 1994

The PPO is Owned by: Publicly owned

The Owner is a:

- ☐ **Hospital**
- ☐ **Clinic**
- ☐ **Association**
- ☐ **Stand Alone Corporation**
- ☒ **Other (Please Specify)** We are a publicly-owned company. Patient Infosystems, Inc. traded under stock under the stock symbol PATY.

Specific PPO Information

Please Specify the Number of Clinics in the N/A

Please Specify the Number of Hospitals in the PPO: N/A

Please Specify the Number of Physicians in the PPO: N/A

Please Specify the Number of any Other Providers such as Home Health Care Facilities, Skilled Nursing Facilities, etc. in the PPO: See attached report

Please list the PPO coverage by geographical areas within a state. If only a portion of a state is covered by the PPO, please indicate the counties where coverage is

National Coverage provided by State on attached report.

Signature of Person Completing the Questionnaire: Tonya Fenimore

Title: Client Services Manager/Midwest **Date:** September 23, 2005

Preferred Provider Organization (PPO) Questionnaire

To Be Attached To Employer Sponsored Group Health Plan

General Information

Complete PPO Name: Signature Care, Inc.

Complete PPO Address: 3000 Coliseum Blvd East Suite 100

Fort Wayne, IN 46805

PPO Phone Number: (260)373-9000 **PPO Fax Number:** (260)373-9010

PPO Customer Service Contact / Title: Chris Johnson – Account Executive

Website Address: www.encoreconnect.com

Please Specify the Date this PPO was Established: 1994

The PPO is Owned by: The Healthcare Group, LLC

The Owner is a:

- ☒ **Hospital**
- ☐ **Clinic**
- ☐ **Association**
- ☐ **Stand Alone Corporation**
- ☐ **Other (Please Specify)**

Specific PPO Information

Please Specify the Number of Clinics in the

Please Specify the Number of Hospitals in the PPO: 25Hospitals

Please Specify the Number of Physicians in the PPO: 1,525 Physicians

Please Specify the Number of any Other Providers such as Home Health Care Facilities, Skilled Nursing Facilities, etc. in the PPO: 275 Ancillary Physicians

Pease list the PPO coverage by geographical areas within a state. If only a portion of a state is covered by the PPO, please indicate the counties where coverage is

Adams, Allen, DeKalb, Elkhart, Fulton, Grant, Huntington, Kosciusko, LaGrange, Noble, St. Joseph, Steuben, Wabash, Wells, and Whitley Counties in Indiana. Defiance, Paulding, VanWert and Williams Counties in Ohio.

Signature of Person Completing the Questionnaire: Chris Johnson

Title: Account Executive **Date:** April 8, 2003