FAIRFAX COUNTY WATER AUTHORITY
HEALTH PLAN

Plan Document and Summary Plan Description
Effective: January 1, 2015
Restated: January 1, 2016
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</tbody>
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ARTICLE I
ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Fairfax County Water Authority (the “Plan Sponsor”) as of January 1, 2016, hereby amends and restates the Fairfax County Water Authority Health Plan (the “Plan”), which was originally adopted by the Company, effective January 1, 2015.

1.01 Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

1.02 Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Fairfax County Water Authority

By: ________________________________

Name: ______________________________

Date: ______________________________  Title: ______________________________
ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

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

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits.

2.02 General Plan Information

Patient Protection and Affordable Care Act
This group health plan believes this plan is a “Grandfathered Health Plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Although not required, the Plan currently covers preventive care at 100% with no deductible (see section 15.01 for more information). However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, VA 22031
703-289-6097

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to Grandfathered Health Plans.

Name of Plan: Fairfax County Water Authority Health Plan

Plan Sponsor: Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, VA 22031
703-289-6097

Fairfax County Water Authority
Health Plan
Plan Document and Summary Plan Description
The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer’s name.

2.03 Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

2.04 Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.05 Mental Health Parity
Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.
2.06  Applicable Law
This is a self-funded benefit plan, funded with employee and/or employer contributions. This plan is subject to Federal law and the laws of the state of Virginia, when applicable.

2.07  Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants’ rights; and to determine all questions of fact and law arising under the Plan.
ARTICLE III
SUMMARY OF BENEFITS

3.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. “Utilization Management” includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled “Cost Containment.”

The following services may require pre-certification (or reimbursement from the Plan may be reduced):

- Inpatient Hospitalization;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);
- Hospice;
- Extended Care;
- Rehabilitation Facilities
- Inpatient Mental/Nervous Facility based programs;
- Inpatient Substance Abuse Facility based programs; and
- Skilled Nursing Facility stays.

Remember that although the Plan will automatically pre-authorize a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important to have your Physician call to obtain pre-certification in case there is a need to have a longer stay.

See pre-certification requirements in the section entitled “Cost Containment” for more details.

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called “Network Providers.” Those who have not contracted with the Networks are referred to in this Plan as “Non-Network Providers.” This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:

   a. In the event a Network Provider refers a Participant to a non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the non-Network Provider will be paid as though the services were provided by a Network Provider.
   b. The Network Provider level of benefits is payable for any Dependent Child who cannot access Network Providers because they reside outside the Network service area.
   c. The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

3.02 Primary Care Providers
A current list of PPO providers is available, without charge, through the Third Party Administrator’s website (located at www.healthscopebenefits.com).

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

3.03 Claims Audit
In addition to the Plan’s Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

3.04 Calendar Year Maximum Benefit
The following calendar year maximums apply to each Participant:

<table>
<thead>
<tr>
<th>Calendar Year Maximum Benefits for:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care</td>
<td>26 Visits</td>
</tr>
<tr>
<td>Hearing Exam</td>
<td>1 Exam</td>
</tr>
<tr>
<td>Hearing Aids (1 appliance every 3 years)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90 Visits</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>1,000 Hours</td>
</tr>
<tr>
<td>Registered Dietician</td>
<td>6 Visits</td>
</tr>
<tr>
<td>Vision (for Participants over age 18)</td>
<td>$500</td>
</tr>
<tr>
<td>All Essential Health Benefits</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>
### 3.05 Summary of Medical Benefits

The following benefits are per Participant per calendar year:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$235</td>
<td>$470</td>
</tr>
<tr>
<td>Family Unit</td>
<td>$470</td>
<td>$940</td>
</tr>
<tr>
<td>Network and Non-Network charges cross-apply to satisfy the Deductible. The Family Unit Deductible is met when two family members have each met the Individual Deductible amount.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Payment Level (unless otherwise stated)</strong></td>
<td>90%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Maximum Out-of-Pocket</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,180</td>
<td>$1,770</td>
</tr>
<tr>
<td>Family Unit</td>
<td>$2,360</td>
<td>$3,540</td>
</tr>
<tr>
<td>Network and Non-Network charges cross-apply to satisfy the Maximum Out-of-Pocket. Does not include prescription copays, charges for TMJ, penalties and excluded charges. The Family Unit Maximum Out-of-Pocket is met when two family members have each reached the Individual Maximum Out-of-Pocket.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Covered Medical Expenses:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abortion</td>
<td>$25 Copay</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Acupuncture</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Covered as an anesthetic agent for covered surgeries only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Allergy Services</td>
<td>$25 Copay</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Testing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Serum</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Limited to 50 miles per trip.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Ambulance</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>5. Ambulatory Surgical Center</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>6. Anesthesia</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>7. Biofeedback</td>
<td>$25 Copay</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered if services are Medically Necessary for a covered condition.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Birthing Center</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>9. Birth Control</td>
<td>$25 Copay</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Breast Pumps</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>11. Cardiac Rehabilitation</td>
<td>$25 Copay</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td>90% after Deductible</td>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes Phase I and Phase II only.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td>12.</td>
<td>Chiropractic Care</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited to 26 visits per calendar year.</td>
</tr>
<tr>
<td>13.</td>
<td>Dental Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Includes treatment for accidental injuries if repair is made within 3 months of the injury, excision of lesions, and incision of accessory sinus, mouth, salivary glands or ducts.</td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>15.</td>
<td>Durable Medical Equipment</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Includes routine maintenance, repair, and replacement if necessary due to the Participant’s growth and development or replacement is less costly than repair. Insulin infusion pumps are limited to 1 every 5 years.</td>
</tr>
<tr>
<td>16.</td>
<td>Glaucoma, Cataract Surgery and Lenses (one set)</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>17.</td>
<td>Hearing Exams and Hearing Aids</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>50% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hearing exam limited to 1 per calendar year. Hearing aids limited to $1,000 per calendar year and 1 new appliance every 3 years.</td>
</tr>
<tr>
<td>18.</td>
<td>Home Health Care</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covered if treatment begins within 7 days of a hospital confinement for the same condition. Limited to 90 visits per calendar year.</td>
</tr>
<tr>
<td>19.</td>
<td>Hospice Care</td>
<td>100% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-certification is required. Limited to a lifetime maximum of 60 inpatient days and 225 days for inpatient and outpatient services combined. Respite care is not covered.</td>
</tr>
<tr>
<td>20.</td>
<td>Hospital</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient Treatment</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Outpatient Treatment</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-certification is required for inpatient treatment, excluding a length of stay not in excess of 48 hours (or 96 hours) following birth of a child.</td>
</tr>
<tr>
<td>21.</td>
<td>Morbid Obesity Treatment</td>
<td>$25 Copay</td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See section 15.01 for more information.</td>
</tr>
<tr>
<td>22.</td>
<td>Newborn Care</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>23.</td>
<td>Occupational Therapy</td>
<td>$25 Copay</td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>24.</td>
<td>Orthotics</td>
<td>$25 Copay</td>
</tr>
<tr>
<td></td>
<td>Office Visit</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Other Services</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Replacement is covered if less costly than repair of device.</td>
</tr>
<tr>
<td>25.</td>
<td>Outpatient Diagnostic X-ray and Lab</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Services as part of the Lab Card program are paid at 100% no Deductible.</td>
</tr>
<tr>
<td>Service Category</td>
<td>Office Visit Copay</td>
<td>Office Visit Deductible</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>26. Outpatient Emergency Services</td>
<td>$55</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td></td>
<td>Copay if waived if Participant is admitted.</td>
<td></td>
</tr>
<tr>
<td>27. Physical Therapy</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Physician Services</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lab, x-rays and Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Podiatry Services</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease) is excluded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Pregnancy Expenses</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excludes charges related to surrogacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Preventive Care</td>
<td>100%</td>
<td>no Deductible</td>
</tr>
<tr>
<td></td>
<td>See section 15.01 for more information.</td>
<td></td>
</tr>
<tr>
<td>32. Private Duty Nursing</td>
<td>90%</td>
<td>after Deductible</td>
</tr>
<tr>
<td></td>
<td>Limited to 1,000 hours per calendar year. Each visit is limited to 8 hours in a 24 hour period.</td>
<td></td>
</tr>
<tr>
<td>33. Prosthetics</td>
<td>90%</td>
<td>after Deductible</td>
</tr>
<tr>
<td></td>
<td>Includes replacement if necessary due to the Participant’s growth and development or equipment was initially provided more than 5 years prior.</td>
<td></td>
</tr>
<tr>
<td>34. Psychiatric Expenses</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-certification is required for inpatient treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. Registered Dietician</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 6 visits per calendar year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. Skilled Nursing Facility</td>
<td>90%</td>
<td>after Deductible</td>
</tr>
<tr>
<td></td>
<td>Pre-certification is required. Stay must begin within 14 days of a hospital confinement of at least 5 days.</td>
<td></td>
</tr>
<tr>
<td>37. Sleep Disorders</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes treatment for sleep apnea, nocturnal seizures and narcolepsy. Oral appliances are excluded.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Speech Therapy</td>
<td>$25</td>
<td>90% after Deductible</td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered for speech loss or impairment due to illness or injury. See section 15.01 for more information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Substance Abuse Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$25 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$35 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>70% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-certification is required for inpatient treatment.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>40. Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% after Deductible</td>
</tr>
<tr>
<td>70% after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>41. Temporomandibular Joint Disorder (TMJ)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office Visit</td>
</tr>
<tr>
<td>• Other Services</td>
</tr>
<tr>
<td>$25 Copay</td>
</tr>
<tr>
<td>50% after Deductible</td>
</tr>
<tr>
<td>$35 Copay</td>
</tr>
<tr>
<td>50% after Deductible</td>
</tr>
<tr>
<td>Limited to non-surgical treatment or diagnosis only. Charges do not apply to Maximum Out-of-Pocket.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>42. Transplants</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% after Deductible</td>
</tr>
<tr>
<td>70% after Deductible</td>
</tr>
<tr>
<td>Pre-certification is required. Center of Excellence is required for Network benefits to apply. See section 15.01 for more information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>43. Urgent Care Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office Visit</td>
</tr>
<tr>
<td>• Other Services</td>
</tr>
<tr>
<td>$25 Copay</td>
</tr>
<tr>
<td>90% after Deductible</td>
</tr>
<tr>
<td>$35 Copay</td>
</tr>
<tr>
<td>70% after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>44. Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Routine Exam</td>
</tr>
<tr>
<td>• Contacts, Lenses, Frames</td>
</tr>
<tr>
<td>100% no Deductible</td>
</tr>
<tr>
<td>50% no Deductible</td>
</tr>
<tr>
<td>100% no Deductible</td>
</tr>
<tr>
<td>50% no Deductible</td>
</tr>
<tr>
<td>Limited to $500 per calendar year for contacts, lenses and frames. Includes 1 eye exam per calendar year (not applied to annual maximum). Excludes surgery.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>45. Wigs</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% after Deductible</td>
</tr>
<tr>
<td>90% after Deductible</td>
</tr>
<tr>
<td>Covered for hair loss due to chemotherapy or surgery.</td>
</tr>
</tbody>
</table>
ARTICLE IV
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.

“Accident”
“Accident” shall mean a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

“Accidental Bodily Injury”
“Accidental Bodily Injury” shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

“ADA”
“ADA” shall mean the American Dental Association.

“Adverse Benefit Determination”
“Adverse Benefit Determination” shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.

“Affordable Care Act (ACA)”
The “Affordable Care Act (ACA)” means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

“AHA”
“AHA” shall mean the American Hospital Association.

“Allowable Expenses”
“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan’s Allowable Expenses shall consist of the Plan Participant's responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

“Alternate Recipient”
“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.
“AMA”
“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”
“Ambulatory Surgical Center” shall mean any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

“Assignment of Benefits”
“Assignment of Benefits” shall mean an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” as consideration in full for services, supplies, and/or treatment rendered.

“Birthing Center”
“Birthing Center” shall mean a facility that meets professionally recognized standards and all of the following requirements:

1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated Pregnancy, in a home-like atmosphere.
2. It has the following: at least 2 delivery rooms; all the medical equipment needed to support the services furnished by the facility; laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening situations.
3. It has medical staff that: is supervised by a Physician on a full-time basis; and includes a Registered Nurse at all times when Covered Persons are at the facility.
4. If it is not part of a Hospital, it has a written agreement with a local Hospital and a local ambulance company for the immediate transfer of Covered Persons who develop complications or who require either pre or post-natal care.
5. It admits only Covered Persons who: have undergone an educational program to prepare them for the birth; and have medical records of adequate prenatal care.
6. It schedules confinements of not more than 24 hours for a birth.
7. It maintains medical records for each Covered Person.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

“Break in Service”
“Break in Service” means a period of at least 13 consecutive Weeks during which the Employee has no Hours of Service, as defined herein. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive Weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves absence prescribed herein).

“Cardiac Care Unit”
“Cardiac Care Unit” shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the treatment of patients who require special medical attention because of their critical condition;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Centers of Excellence”
“Centers of Excellence” shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

“Certificate of Coverage”
“Certificate of Coverage” shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child”
“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

“CHIP”
“CHIP” refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

“CHIPRA”
“CHIPRA” refers to the Children’s Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

“Chiropractic Care”
“Chiropractic Care” shall mean office visits, x-rays, manipulations, supplies, heat treatment, cold treatment and massages.

“Claim Determination Period”
“Claim Determination Period” shall mean each calendar year.

“Clean Claim”
A “Clean Claim” is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims
under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

_Filing a Clean Claim._ A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

**“COBRA”**

“COBRA” shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**“Cosmetic Surgery”**

“Cosmetic Surgery” shall mean any Surgery, service, Drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

**“Covered Expense”**

“Covered Expense” means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

**“Covered Mental Health Service Providers”**

“Covered Mental Health Service Providers” are physicians and associated visits which are limited and subject to the Summary of Benefits and terms of this document. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors licensed to provide individual psychotherapy without supervision in the State they are practicing, may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

**“Creditable Coverage”**

“Creditable Coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a State health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

**“Custodial Care”**

“Custodial Care” shall mean care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but
is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible”
“Deductible” shall mean an amount of money that is paid once a calendar year per Participant and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required.

“Dentist”
“Dentist” shall mean an individual holding a D.D.S. or D.M.D. degree, licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent”
“Dependent” shall mean one or more of the following person(s):

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, “marriage or married” means a legal union between a couple of the same or opposite sex;
2. An Employee’s Child who is less than 26 years of age. Coverage shall continue through the end of the month in which the Child reaches age 26; and
3. An Employee’s Child, regardless of age, who was continuously covered prior to attaining the limiting age in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age in the numbers above. The time limit for written proof of incapacity and dependency is 31 days following the original eligibility date for a new or re-enrolling Employee. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

“Dependent” does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

“Detoxification”
“Detoxification” shall mean the process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

“Diagnosis”
“Diagnosis” shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

“Diagnostic Service”
“Diagnostic Service” shall mean a test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

“Disease”
“Disease” shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any worker’s
compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime
doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law
or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a Sickness, Illness or Disease.

“Drug”
“Drug” shall mean insulin and prescription legend drugs. A prescription legend drug is a Federal legend drug (any
medicinal substance which bears the legend: “Caution: Federal law prohibits dispensing without a prescription”) or
a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State
law) and which, in either case, is legally obtained from a licensed drug dispenser only upon a prescription of a
currently licensed Physician.

“Durable Medical Equipment”
“Durable Medical Equipment” shall mean equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

“Emergency”
“Emergency” shall mean a situation where necessary treatment is required as the result of a sudden and severe
medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies
and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist.
The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

“Emergency Medical Condition”
“Emergency Medical Condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient
severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and
medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in
clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that
provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a
pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious
impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

“Emergency Services”
“Emergency Services” shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C.
1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services
routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff
and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42
U.S.C. 1395dd) to stabilize the patient.

“Employee”
“Employee” shall mean the classes of Employees who are eligible for coverage under the Plan as set forth in the
Eligibility for Coverage section of this Summary Plan Description and the Plan’s Eligibility Appendix. Contact the
Plan Administrator for more information or to obtain a copy of the Plan’s Eligibility Appendix.

“Essential Health Benefits”
“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act,
those health benefits to include at least the following general categories and the items and services covered within the
categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental
health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative
and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease
management; and pediatric services, including oral and vision care.
“Experimental” and/or “Investigational”  
“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA’s Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
4. A clinical study or review article in a reviewed professional journal.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

“Family Unit”  
“Family Unit” shall mean the Employee, his or her Dependents covered under the Plan.
“FMLA”
“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”
“FMLA Leave” shall mean a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

“GINA”
“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

"Genetic Testing"
"Genetic Testing" shall mean medical tests used to identify changes in chromosomes, genes or proteins.

“Health Breach Notification Rule”

“HIPAA”
“HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

“Home Health Care”
“Home Health Care” shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if home health care was not provided;
2. The treatment plan covering the home health care service is established and approved in writing by the attending Physician; and
3. The home health care is the result of an Illness or Injury.

“Home Health Care Agency”
“Home Health Care Agency” shall mean an agency or organization which provides a program of home health care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
3. Meets all of the following requirements:
   a. It is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home;
   b. It has a full-time administrator;
   c. It maintains written records of services provided to the patient;
   d. Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
   e. Its employees are bonded and it provides malpractice insurance.

“Hospital”
“Hospital” shall mean an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA.

“Hospital” shall also have the same meaning, where appropriate in context, set forth in the definition of “Ambulatory Surgical Center.”

“Hours of Service”
“Hours of Service” means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

1. Vacation
2. Holiday
3. Illness or incapacity
4. Layoff
5. Jury duty
6. Military duty or leave of absence.

“Illness”
“Illness” shall have the meaning set forth in the definition of “Disease.”

“Impregnation and Infertility Treatment”
“Impregnation and Infertility Treatment” shall mean artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, sterilization and/or reversal of a sterilization operation, surrogate mother, donor eggs, or any type of artificial impregnation procedure, whether or not such procedure is successful.

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

“Initial Measurement Period”
For “Initial Measurement Period” please refer to the Plan’s Eligibility Appendix.

“Injury”
“Injury” shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

“Inpatient”
“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.
“Institution”
“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

“Intensive Care Unit”
“Intensive Care Unit” shall have the same meaning set forth in the definition of “Cardiac Care Unit.”

“Late Enrollee”
“Late Enrollee” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

“Leave of Absence”
“Leave of Absence” shall mean a leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

“Mastectomy”
“Mastectomy” shall mean the surgical removal of all or part of a breast.

“Maximum Amount” or “Maximum Allowable Charge”
“Maximum Amount” and/or “Maximum Allowable Charge” shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The Reasonable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

“Medical Child Support Order”
“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“Medically Necessary”
“Medical Care Necessity”, “Medically Necessary”, “Medical Necessity” and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Plan Participant for the purposes
of evaluation, diagnosis or treatment of that Plan Participant’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant’s Sickness or Injury without adversely affecting the Plan Participant’s medical condition.

A) It must not be maintenance therapy or maintenance treatment.
B) Its purpose must be to restore health.
C) It must not be primarily custodial in nature.
D) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
E) The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant’s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “Medically Necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “Medically Necessary” does not mean that any other services are deemed to be “Medically Necessary.”

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

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

a. The Drug is approved by the FDA;
b. The prescribed Drug use is supported by one of the following standard reference sources:
   1) DRUGDEX;
   2) The American Hospital Formulary Service Drug Information;
   3) Medicare approved Compendia; or
   4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and
c. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

“Medical Record Review”
“Medical Record Review” is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

“Medicare”
“Medicare” shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)”
“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:
1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

“Mental or Nervous Disorder”
“Mental or Nervous Disorder” shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

“National Medical Support Notice” or “NMSN”
“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

“Network”
“Network” shall mean the medical provider network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participants identification card.

“New Employee Stability Period”
“New Employee Stability Period” means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee’s anniversary date.

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

“Non-Occupational Injury”
“Non-Occupational Injury” shall have the meaning set forth in the definition of “Injury.”

“Non Network Fee Schedule (NNFS)”
“Non Network Fee Schedule (NNFS)” is a fee schedule used to re-price non-network claims.

“Ongoing Employee”
“Ongoing Employee” shall have the same meaning as Ongoing Employee set forth in the Summary Plan Description.

“Ongoing Employee Stability Period”
“Ongoing Employee Stability Period” means the 12 Calendar Month period that begins on the first day of each Plan Year following the end of the Plan’s Standard Measurement Period.
“Open Enrollment Period”
“Open Enrollment Period” shall mean the period of time as determined by the Plan Administrator in each Plan Year.

“Other Plan”
“Other Plan” shall include, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy covering the Participant;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker’s compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

“Participant” / “Plan Participant”
“Participant” shall mean any Employee or retiree or Dependent who is eligible for benefits under the Plan.

“Patient Protection and Affordable Care Act (PPACA)”
The “Patient Protection and Affordable Care Act (PPACA)” means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See “Affordable Care Act”).

“Physician”
“Physician” shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), psychiatrist or midwife.

“Plan Year”
“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Pre-admission Tests”
“Pre-admission Tests” shall mean those Diagnostic Services done prior to scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the Surgery.

“Preferred Provider Organization (PPO)”
“Preferred Provider Organization (PPO)” shall mean an organization that contracts with a network of providers from which the health plan Participant can choose. Participants do not need to select a primary care physician (PCP) and do not need referrals to see other providers in the network.

“Pregnancy”
“Pregnancy” shall mean carrying a child, resulting childbirth, miscarriage and abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

“Prior Plan”
“Prior Plan” shall mean the coverage provided on a group or group-type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.
“Prior to Effective Date” or “After Termination Date”
“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

“Privacy Standards”
“Privacy Standards” shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

“Provider”
“Provider” shall mean a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

“Psychiatric Hospital”
“Psychiatric Hospital” shall mean an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a Physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a Physician; and
5. It provides 24-hour-a-day nursing service.

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

“Qualified Medical Child Support Order” or “QMCSO”
“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan.

“Qualifying Part-time Employee”
“Qualifying Part-time Employee” shall have the same meaning as Qualifying Part-time Employee set forth in the Summary Plan Description.

“Reasonable”
“Reasonable” and/or “Reasonableness” shall mean in the administrator’s discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.
Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

“Regular Full-time Employee”
“Regular Full-time Employee” means a common law employee who is regularly scheduled to work thirty (30) Hours of Service or more per week.

“Rehabilitation Hospital”
“Rehabilitation Hospital” shall mean an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

“Retiree”
“Retiree” shall mean a retired Employee of the Employer who is under age 65.

“Room and Board”
“Room and Board” shall mean a Hospital’s charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

“Seasonal Employee”
“Seasonal Employee” means an Employee hired by the Employer into a position that is typically no longer in duration than 6 months and begins at the same time of the year each year.

“Scheduled benefit” or “Scheduled benefit amount” means a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of scheduled benefit amounts may be found in the section, “Summary of Benefits”.

“Security Standards”
“Security Standards” shall mean the final rule implementing HIPAA’s Security Standards for the Protection of Electronic PHI, as amended.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time during which the Employee is in the continuous, Active Employment of his or her Participating Employer.

“Sickness”
“Sickness” shall have the meaning set forth in the definition of “Disease.”
“Standard Measurement Period”
For “Standard Measurement Period” please refer to the Plan’s Eligibility Appendix.

“Substance Abuse”
“Substance Abuse” shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
3. Craving or a strong desire or urge to use a substance;
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”
“Substance Abuse Treatment Center” shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) substance abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

“Surgery”
“Surgery” shall mean any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

“Surgical Procedure”
“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”
“Total Disability”
“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

“Totally Disabled”
“Totally Disabled” shall have the same meaning set forth in the definition of “Total Disability.”

“Uniformed Services”
“Uniformed Services” shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

“USERRA”
“USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Usual and Customary”
“Usual and Customary” (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

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

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.
ARTICLE V
ELIGIBILITY FOR COVERAGE

5.01 Eligibility for Individual Coverage
The following classes of Employees will be eligible for coverage under the Plan:

1. New Hires -
   a. Regular Full-time Employees: Employees designated by the Employer as Regular Full-time Employees. Coverage for Regular Full-time Employees hired between the 1st and 15th of the month, if properly elected, will be effective the first day of the calendar month following the Employee’s date of hire. Coverage for Regular Full-time Employees hired between the 16th and 31st of the month, if properly elected, will be effective the first day of the second calendar month following the Employee’s date of hire.
   b. Qualifying Part-time Employee: Employees designated by the Employer as Regular Part-time Employees, regularly scheduled to work at least 20 Hours of Service per week and are on the regular payroll of the Employer. Coverage for Regular Part-time Employees hired between the 1st and 15th of the month, if properly elected, will be effective the first day of the calendar month following the Employee’s date of hire. Coverage for Regular Part-time Employees hired between the 16th and 31st of the month, if properly elected, will be effective the first day of the second calendar month following the Employee’s date of hire.

Note: if there is a gap between the end of the Qualifying Part-time Employee’s New Employee Stability Period and the start of the Qualifying Part-time Employee’s first Ongoing Employee Stability Period (see below), the Qualifying Part-time Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period to the extent the employee remains employed, subject to the Plan’s Break in Service rules.

If a Qualifying Part-time Employee transfers to a Regular Full-time Employee position prior to the start of the Qualifying Part-time Employee’s New Employee Stability Period, the Employee will become eligible for coverage. Coverage for Regular Full-time Employees hired between the 1st and 15th of the month, if properly elected, will be effective the first day of the calendar month following the Employee’s date of hire. Coverage for Regular Full-time Employees hired between the 16th and 31st of the month, if properly elected, will be effective the first day of the second calendar month following the Employee’s date of hire.

2. “Ongoing” Employees - Once an Employee has completed the Plan’s Standard Measurement Period, eligibility will be based solely on the Employee’s Hours of Service during the Plan’s Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan’s Standard Measurement Period (“Ongoing Employees”) will be eligible for coverage under the Plan during the Plan’s next Ongoing Employee Stability Period to the extent that the Ongoing Employee remains employed, subject to the Plan’s Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan’s Ongoing Employee Stability Period.

Whether an Employee averages 30 Hours of Service per week will be determined in accordance with policies and procedures adopted by the Plan Administrator.

Impact of Breaks In Service
Any Employee who resumes Hours of Service following a Break in Service (as defined in the Plan Eligibility Appendix) will be treated as a New Hire and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. If, however, the Employee experiences a period without any Hours of Service, and resumes Hours of Service without experiencing a Break in Service, the Employee will be treated as a continuous employee. A continuous employee resuming Hours of Service after a period with no Hours of Service that does not constitute a Break in Service will be eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period.
with No Hours of Service. Such coverage will be effective on the first day of the month that coincides with or follows the date you resume Hours of Service.

If you wish to review a copy of the Plan’s Eligibility Appendix, please contact the Plan Administrator.

5.02 Eligibility for Retiree Coverage
A person under the age of 65 is eligible for Retiree coverage from the first day of the month that he or she:

1. Is a Retiree of the Employer and was enrolled in coverage prior to his or her retirement;
2. Spouses under the age of 65 and Dependents of a Retiree are also eligible provided they meet the requirements stated in the section entitled “Eligibility for Dependent Coverage.”

5.02 Eligibility Dates for Dependent Coverage
Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

Any reference in this Plan to an Employee’s Dependent being covered means that such Employee is covered for Dependent Coverage.

5.03 Effective Dates of Coverage; Conditions
The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 31-day period immediately following the date of eligibility.

2. Birth of Dependent Child. If a Dependent Child is born after the date the Employee’s coverage for himself or herself under the Plan becomes effective and the Employee has coverage under this Plan for his or her Dependents, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child. Such coverage shall continue for the 31-day period commencing on the date of birth. In order to continue such coverage after the 31st day, prior to the end of the 31-day period, the Employee must make written application to the Plan for such Child and agree to make any required contribution.

If the Employee does not have coverage under this Plan for any Dependents at the date of such Child’s birth, then coverage for such Child shall be available only if, during the first 31 days following the date of birth, the Employee makes written application to the Plan for such Child and agrees to make any required contribution. In that event, coverage will be effective as of the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 31 days of the date of eligibility and any required contributions are made.
4. **Requirement for Employee Coverage.** No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.

5. **Coverage as Both Employee and Dependent.** No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

6. **Medicaid Coverage.** An individual’s eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual’s eligibility under the Plan.

7. **FMLA Leave.** Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

### 5.04 Special and Open Enrollment

The Plan provides special enrollment periods that allow Employee’s to enroll in the Plan, even if they declined enrollment during an initial or subsequent eligibility period.

#### 5.04A Loss of Other Coverage

If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents if the other health coverage is lost. The Employee must make written application for special enrollment within 30 days of the date the other health coverage was lost.

**The following conditions apply to any eligible Employee and Dependents:**

An Employee may enroll during this special enrollment period:

1. If the Employee is eligible for coverage under the terms of this Plan;
2. The Employee is not currently enrolled under the Plan;
3. When enrollment was previously offered, the Employee declined because of coverage under another group health plan or health insurance coverage. The Employee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
4. If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An Employee who is already enrolled in a benefit package may enroll in another benefit package under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit package within 30 days of the date the other health coverage was lost.

The Employee is not eligible for this special enrollment right if:

1. The other coverage was COBRA continuation coverage and the Employee did not exhaust the maximum time available to him or her for that COBRA coverage; or
2. The other coverage was lost due to non-payment of requisite contribution / premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.
5.04B New Dependent
If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 30 days after he or she acquires the new Dependent.

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll himself or herself and/or his or her eligible Dependents during this special enrollment period if:

1. The Employee is eligible for coverage under the terms of this Plan; and
2. The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for the Employee and his or her Dependent(s) will be effective at 12:01 A.M.:

1. For a marriage, on the first day of the calendar month following enrollment;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

5.04C Additional Special Enrollment Rights
Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee’s or Dependent’s Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

5.04D Open Enrollment
Participants may enroll for coverage during Open Enrollment Periods. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1st, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

“Open Enrollment Period” shall mean the period of time as determined by the Plan Administrator in each Plan Year.

5.04E Effective Date of Coverage; Conditions
All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled “Effective Dates of Coverage; Conditions,” will apply to Participants enrolling during a Special or Open Enrollment Period. Coverage for Participants enrolling during a Special Enrollment Period will become effective on the first day of the month following the receipt by the Plan of the Participant’s enrollment form, in the case of enrollment due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

5.05 Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.
“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent.

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

“National Medical Support Notice” or “NMSN” shall mean a notice that contains the following information:

1. Name of an issuing State child support enforcement agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan or eligible for enrollment;
3. Name and mailing address each of the Alternate Recipients (i.e., the child or children of the Participant or the name and address of a State or local office may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

“Qualified Medical Child Support Order” or “QMCSO” is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

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

1. Contains the information set forth above in the definition of “National Medical Support Notice”;
2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;
   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and
3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Plan Participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support
orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

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

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

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

1. Notify the State agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and

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

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

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

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

5.06 Late Enrollee

“Late Enrollee” shall mean a Participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or

2. Through special enrollment.

5.07 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the prior plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

5.08 “GINA”

“GINA” prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.
The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

5.09 Effect of Section 125 Tax Regulations on This Plan
The Plan Administrator has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, by enrolling in this plan, the Participant agrees to pretax salary reduction put toward the cost of his or her benefits.

Coverage Elections: Per Section 125 regulations, Participants are generally allowed to enroll for or change Coverage only during each annual enrollment period. However, exceptions are allowed if the Plan Administrator agrees and the Participant enrolls for or changes coverage within thirty one (31) days of the date the Participant meets the criteria shown below. The change must be consistent with the event.

Change of Status: A change in status is defined as:

- Change in legal marital status due to marriage, death of a spouse, or divorce;
- Change in number of dependents due to birth, adoption, placement for adoption, or death of a dependent;
- Change in employment status of employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- Changes in employment status of employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
- Changes which cause a dependent to become eligible or ineligible for coverage; and
- Change in residence from the network coverage area.

Court Order: A change in Coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare or Medicaid Eligibility/Entitlement: The Employee, Spouse or Dependent cancels or reduces Coverage due to entitlement to Medicare or Medicaid, or enrolls or increases Coverage due to loss of Medicare or Medicaid eligibility. The Employee or Dependent must request to enroll or cancel Coverage within sixty (60) days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.

Children’s Health Insurance Program (CHIP): Employees and Dependents who are eligible but not enrolled for Coverage may enroll if: 1) the Employee’s or Dependent’s Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or 2) the Employee or Dependent becomes eligible for a subsidy under Medicaid or CHIP. The Employee or Dependent must request to enroll or cancel Coverage within sixty (60) days after the Employee or Dependent is terminated from, or determined to be eligible, for such assistance.
**Change in Cost of Coverage:** If the cost of benefits increases or decreases during a benefit period, the Plan Administrator may, in accordance with plan terms, automatically change the Participant’s elective contribution.

When the change in cost is significant, the Participant may either increase his or her contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option the Participant has elected, the Participant may elect another available benefit option. When a new benefit option is added, the Participant may change his or her election to the new benefit option.

**Changes in Coverage of Spouse or Dependent Under Another Employer’s Plan:** The Participant may make a Coverage election change if the plan of the Participant’s Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of Coverage or open enrollment periods.

**Revocation Due to Reduction in Hours:** The Participant may revoke coverage under this Plan if he or she experiences a change in employment status so that the Participant is reasonably expected to average less than 30 hours of service per week, even if such a change does not cause the Participant to be ineligible, and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in another plan that provides minimum essential coverage with an effective date no later than the first day of the second month following the date coverage under this Plan is revoked.

**Revocation Due to Enrollment in a Qualified Health Plan:** The Participant may revoke coverage under this Plan if he or she is eligible for a Special Enrollment Period in a Qualified Health Plan through a Marketplace or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace’s annual open enrollment period and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in a Qualified Health Plan through a Marketplace for new coverage with an effective date no later then the day immediately following the last day of coverage under this Plan.

There may be additional situations that qualify for a special enrollment opportunity. Contact the Plan Administrator for additional details.
ARTICLE VI
TERMINATION OF COVERAGE

6.01 Termination Dates of Individual Coverage
The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. If the Employee is terminated between the 1st and the 15th of the month, coverage will terminate the last day of the month in which the Employee is terminated. If the Employee is terminated between the 16th and the 31st of the month, coverage will terminate the last day of the second calendar month after the Employee is terminated;
2. The last day of the month following termination of the Plan;
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
4. The last day of the month in which he or she ceases to be eligible for such coverage under the Plan; or
5. The date on which an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

6.02 Termination Dates of Retiree Coverage
The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The first day of the month in which the Retiree reaches age 65;
2. The date of termination of the Plan;
3. The date of death of the covered Retiree; or
4. The date of the expiration of the last period for which the Retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.

6.03 Termination Dates of Dependent Coverage
The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee’s coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
   a. Cessation of such inability;
   b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
   c. Upon the Child’s no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.
6.04 Prohibition on Rescission
The Plan will not rescind coverage for Covered Persons. This provision does not apply to cases where the Covered Person has engaged in fraud or made an intentional misrepresentation of material fact and advance notice of rescission is made by the Plan.
ARTICLE VII
CONTINUATION OF COVERAGE

7.01 Employer Continuation Coverage
Coverage will be continued in the event of a personal leave of absence which does not meet the requirements of FMLA Leave for a period of one year following the date on which the Employee took his or her personal leave of absence.

7.02 Continuation During FMLA Leave
Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

The Family and Medical Leave Act is a Federal law that applies, generally, to employers with 50 or more Employees, and provides that an eligible Employee may elect to continue coverage under this Plan during a period of approved FMLA Leave at the same cost as if the leave had not been taken.

If provisions under the Plan change while an Employee is on FMLA Leave, the changes will be effective for him or her on the same date as they would have been had he or she not taken leave.

7.02A Eligible Employees
Employees are eligible for FMLA Leave if all of the following conditions are met:

1. The Employee has been employed with the Participating Employer for at least 12 months;
2. The Employee has been employed with the Participating Employer at least 1,250 hours during the 12 consecutive months prior to the request for FMLA Leave; and
3. The Employee is employed at a worksite that employs at least 50 employees within a 75-mile radius.

7.02B Qualifying Circumstances for FMLA Leave
Coverage under FMLA Leave is limited to a total of 12 workweeks during any 12-month period that follows:

1. The birth of, and to care for, a Son or Daughter;
2. The placement of a Child with the Employee for adoption or foster care;
3. The Employee’s taking leave to care for his or her Spouse, Son or Daughter, or Parent who has a Serious Health Condition;
4. The Employee’s taking leave due to a Serious Health Condition which makes him or her unable to perform the functions of his or her position; or
5. A Qualifying Exigency arising out of the fact that a Spouse, Son or Daughter, Parent, or Next of Kin of the Employee is a member of a regular or reserve component of the Armed Forces and is on (or has been notified of impending call to) covered active duty.

Coverage under FMLA Leave is limited to a total of 26 workweeks during any 12-month period for the following situations:

1. To care for a covered service member following a Serious Illness or Injury to that covered service member, when the Employee is that service member’s Spouse, Son or Daughter, Parent, or Next of Kin; or
2. To care for a veteran who is undergoing medical treatment, recuperation, or therapy for a Serious Illness or Injury that occurred any time during the five years preceding the date of treatment, when the Employee is that veteran’s Spouse, Son or Daughter, Parent, or Next of Kin.

*The FMLA definitions of “serious Injury or Illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition”.*
This leave may be considered as a paid (accrued vacation time, personal leave or family or sick leave, as applicable) or unpaid leave. The Participating Employer has the right to require that all paid leave be used prior to providing any unpaid leave.

An Employee must continue to pay his or her portion of the Plan contribution, if any, during the FMLA Leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

7.02C Notice Requirements
An Employee must provide at least 30 days’ notice to his or her Participating Employer prior to beginning any leave under FMLA. If the nature of the leave does not permit such notice, the Employee must provide notice of the leave as soon as possible. The Participating Employer has the right to require medical certification to support the Employee’s request for leave due to a Serious Health Condition for the Employee or his or her eligible family members.

7.02D Length of Leave
During any one 12-month period, the maximum amount of FMLA Leave may not exceed 12 workweeks for most FMLA related situations. The maximum periods for an Employee who is the primary care giver of a service member with a Serious Illness or Injury that was Incurred in the line of active duty may take up to 26 weeks of FMLA Leave in a single 12-month period to care for that service member. The Participating Employer may use any of four methods for determining this 12-month period.

If the Employee and his or her Spouse are both employed by the Participating Employer, FMLA Leave may be limited to a combined period of 12 workweeks, for both Spouses, when FMLA Leave is due to:

1. The birth or placement for adoption or foster care of a Child; or
2. The need to care for a Parent who has a Serious Health Condition.

7.02E Termination of FMLA Leave
Coverage may end before the maximum 12-week (or 26-week) period under the following circumstances:

1. When the Employee informs his or her Participating Employer of his or her intent not to return from leave;
2. When the employment relationship would have terminated but for the leave (such as during a reduction in force);
3. When the Employee fails to return from the leave;
4. If any required Plan contribution is not paid within 30 days of its due date;
5. The Participating Employer and/or Plan Administrator is advised and/or determines that no FMLA Qualifying Circumstance occurred.

If an Employee does not return to work when coverage under FMLA Leave ends, he or she will be eligible for COBRA continuation of coverage at that time, in accordance with the parameters set forth by this Plan and applicable law.

7.02F Recovery of Plan Contributions
The Participating Employer has the right to recover the portion of the Plan contributions it paid to maintain coverage under the Plan during an unpaid FMLA Leave if an Employee does not return to work at the end of the leave. This right will not apply if failure to return is due to the continuation, recurrence or onset of a Serious Health Condition that entitles the Employee to FMLA Leave (in which case the Participating Employer may require medical certification) or other circumstances beyond the Employee’s control.

7.02G Reinstatement of Coverage
The law requires that coverage be reinstated upon the Employee’s return to work following an FMLA Leave whether or not the Employee maintained coverage under the Plan during the FMLA Leave.
On reinstatement, all provisions and limits of the Plan will apply as they would have applied if FMLA Leave had not been taken. The Service Waiting Period will be credited as if the Employee had been continually covered under the Plan.

7.02H Definitions
For this provision only, the following terms are defined as stated.

“Next of Kin”
“Next of Kin” shall mean the nearest blood relative to the service member.

“Parent”
“Parent” shall mean the Employee’s biological parent or someone who has acted as his or her parent in place of his or her biological parent when he or she was a Son or Daughter.

“Qualifying Exigency”
“Qualifying Exigency” shall mean:

1. Short-notice deployment.
   a. To address any issue that arises from the fact that a covered military member is notified seven or less calendar days prior to the date of deployment of an impending call or order to active duty in support of a contingency operation; and
   b. Leave taken for this purpose can be used for a period of seven calendar days beginning on the date a covered military member is notified of an impending call or order to active duty in support of a contingency operation;

2. Military events and related activities.
   a. To attend any official ceremony, program, or event sponsored by the military that is related to the active duty or call to active duty status of a covered military member; and
   b. To attend family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations, or the American Red Cross that are related to the active duty or call to active duty status of a covered military member;

3. Childcare and school activities.
   a. To arrange for alternative childcare when the active duty or call to active duty status of a covered military member necessitates a change in the existing childcare arrangement for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
   b. To provide childcare on an urgent, immediate need basis (but not on a routine, regular, or everyday basis) when the need to provide such care arises from the active duty or call to active duty status of a covered military member for a biological, adopted, or foster Child, a stepchild, or a legal ward of a covered military member, or a Child for whom a covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence;
   c. To enroll in or transfer to a new school or daycare facility, a biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when enrollment or transfer is necessitated by the active duty or call to active duty status of a covered military member; and
   d. To attend meetings with staff at a school or a daycare facility, such as meetings with school officials regarding disciplinary measures, parent-teacher conferences, or meetings with school counselors, for a
biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, when such meetings are necessary due to circumstances arising from the active duty or call to active duty status of a covered military member;

4. Financial and legal arrangements. To make or update financial or legal arrangements to address the covered military member’s absence while on active duty or call to active duty status, such as preparing and executing financial and healthcare powers of attorney, transferring bank account signature authority, enrolling in the Defense Enrollment Eligibility Reporting System (DEERS), obtaining military identification cards, or preparing or updating a will or living trust;

5. Counseling. To attend counseling provided by someone other than a health care Provider for oneself, for the covered military member, or for the biological, adopted, or foster Child, a stepchild, or a legal ward of the covered military member, or a Child for whom the covered military member stands in loco parentis, who is either under age 18, or age 18 or older and incapable of self-care because of a mental or physical disability at the time that FMLA Leave is to commence, provided that the need for counseling arises from the active duty or call to active duty status of a covered military member;

6. Post-deployment activities.
   a. To attend arrival ceremonies, reintegration briefings and events, and any other official ceremony or program sponsored by the military for a period of 90 days following the termination of the covered military member’s active duty status; and
   b. To address issues that arise from the death of a covered military member while on active duty status, such as meeting and recovering the body of the covered military member and making funeral arrangements; and

7. Additional activities. To address other events which arise out of the covered military member’s active duty or call to active duty status provided that the Participating Employer and Employee agree that such leave shall qualify as an exigency, and agree to both the timing and duration of such leave.

“Serious Health Condition”
“Serious Health Condition” shall mean an Illness, Injury, impairment, or physical or mental condition that involves:

1. Inpatient care in a Hospital, hospice, or residential medical facility; or
2. Continuing treatment by a health care Provider (a doctor of medicine or osteopathy who is authorized to practice medicine or Surgery, as appropriate, by the State in which the doctor practices, or any other person determined by the Secretary of Labor to be capable of providing health care services).

“Serious Illness or Injury (of a service member or covered veteran)”
“Serious Illness or Injury” shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member’s active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

“Son or Daughter”
“Son or Daughter” shall mean the Employee’s biological child, adopted child, stepchild, foster child, a child placed in the Employee’s legal custody, or a child for which the Employee is acting as the parent in place of the child’s natural blood related parent.

“Spouse”
“Spouse” shall mean an Employee’s husband or wife.
NOTE: For complete information regarding FMLA rights, contact the Participating Employer.

7.03 Continuation During USERRA
Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. If a Participant elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan’s annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her dependents’ coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating employer for information concerning their eligibility for USERRA and any requirements of the Plan.

7.04 Continuation During COBRA – Introduction
The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Participant or their covered dependents fail to make timely payment of contributions or premiums. Participants should check with their employer to see if COBRA applies to them and/or their covered dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

7.04A COBRA Continuation Coverage
“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer’s plan) are not considered for continuation under COBRA.

7.04B Qualifying Events
Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Plan Participant.” The Employee, the Employee’s spouse, and the Employee’s dependent children could become Qualified Plan Participants if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Plan Participant if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse’s hours of employment are reduced;
3. The spouse’s employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

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

1. The parent-covered Employee dies;
2. The parent-covered Employee’s hours of employment are reduced;
3. The parent-covered Employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (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.

If a proceeding in bankruptcy is filed with respect to Fairfax County Water Authority, and that bankruptcy results in the loss of coverage of any retired employee, spouse, surviving spouse, and Dependent Children covered under the Plan, such member will become a Qualified Plan Participant with respect to the bankruptcy.

7.04C Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

7.04D Employee Notice of Qualifying Events
Each covered Employee or Qualified Plan Participant is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual’s ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Plan Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Plan Participant entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Plan Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Fairfax County Water Authority
8570 Executive Park Avenue
Fairfax, VA 22031
703-289-6097

7.04E Deadline for providing the notice
For Qualifying Events described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.
For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Plan Participant loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Plan Participant is no longer disabled; or
2. The date on which the Qualified Plan Participant is informed, through the furnishing of the Plan’s SPD or the general notice, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

7.04F Who Can Provide the Notice
Any individual who is the covered Employee (or former employee), a Qualified Plan Participant with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Plan Participant, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Plan Participants with respect to the Qualifying Event.

7.04G Required Contents of the Notice
The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Plan Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child’s cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Plan Participant, name and address of the disabled Qualified Plan Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA’s determination, and a copy of the SSA’s determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Plan Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA’s determination; and

10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA’s determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA’s determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA’s determination is provided.

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

7.04H Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Plan Participant will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

7.04I Duration of COBRA Continuation Coverage
COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is “entitlement to Medicare,” the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee’s (or former employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a 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 covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Plan Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).
Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

7.04J Disability Extension of COBRA Continuation Coverage
If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

7.04K Second Qualifying Event Extension of COBRA Continuation Coverage
If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

7.04L Shorter Duration of COBRA Continuation Coverage
COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Plan Participant’s failure to make timely payment of any required contributions or premium;
3. The date that the Qualified Plan Participant first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) except as stated under COBRA’s special bankruptcy rules; or
4. The first day of the month that begins more than 30 days after the date of the SSA’s determination that the Qualified Plan Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

7.04M Contribution and/or Premium Requirements
Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

7.05 Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

    Fairfax County Water Authority
    Plan Administrator
    8570 Executive Park Avenue
    Fairfax, VA 22031
    703-289-6097
For more information about COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.) For more information about the Marketplace, visit www.HealthCare.gov.

7.06  Current Addresses
In order to protect the rights of the Employee’s family, the Employee should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.
ARTICLE VIII
GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does not cover any charge for care, supplies, treatment, and/or services:

**Custodial Care.** That do not restore health, unless specifically mentioned otherwise;

**Excess.** That are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator’s determination as set forth by and within the terms of this document;

**Experimental.** That are Experimental or Investigational;

**Family Member.** That are performed by a person who is related to the Participant as a spouse, parent, child, brother or sister, whether the relationship exists by virtue of “blood” or “in law”;

**Government.** That are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government;

**Illegal Acts.** For services and supplies incurred as a result of an Illness or Injury, caused by or contributed to by engaging in an illegal act, by committing or attempting to commit a crime or by participating in a riot or public disturbance. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

**Inured by Other Persons.** For expenses actually incurred by other persons;

**Medical Necessity.** That are not Medically Necessary;

**No Legal Obligation.** That are provided to a Participant for which the Provider of a service customarily makes no direct charge, or for which the Participant is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Participant or this benefit plan, may be liable for necessitating the fees, care, supplies, or services;

**Not Acceptable.** That are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration;

**Not Actually Rendered.** That are not actually rendered;

**Not Specifically Covered.** That are not specifically covered under this Plan;

**Occupational.** For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational injury medical coverage is available or would have been available had the participant sought to obtain it in accordance with applicable rules and/or procedures;

**Participant Liability Waived.** For charges in connection with a claim where the Participant does not meet his or her cost-sharing responsibility (i.e. copay, deductible or coinsurance). This exclusion applies regardless of whether the Provider charges or attempts to collect the Participant’s cost-sharing responsibility.
Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Self-inflicted. That are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Subrogation, Reimbursement, and/or Third Party Responsibility. That are of an Injury or Sickness not payable by virtue of the Plan’s subrogation, reimbursement, and/or third party responsibility provisions; and

War. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Participant is a member of the armed forces of any Country, or during service by a Participant in the armed forces of any Country. This exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a documented medical condition.
ARTICLE IX
PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

9.01 Plan Administrator
The Plan is administered by the Plan Administrator in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

9.02 Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant’s rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
11. To perform each and every function necessary for or related to the Plan’s administration.

9.03 Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any). This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.
9.04 Final Authority of the Plan Document
The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not effect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

9.05 Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered Participant of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.
ARTICLE X
CLAIM PROCEDURES; PAYMENT OF CLAIMS

The procedures outlined below must be followed by Participants to obtain payment of health benefits under this Plan.

10.01 Health Claims
All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a “claim,” since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a “Post-service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan’s design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A “Pre-service Claim” is a 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. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no “Pre-service Claim.” The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

A “Pre-service Urgent Care Claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

The Plan does not require the Participant to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.
Pre-admission certification of a non-emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. **Concurrent Claims.** A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or
   b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

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

3. **Post-service Claims.** A “Post-service Claim” is a claim for a benefit under the Plan after the services have been rendered.

**10.01A When Claims Must Be Filed**

Claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) were incurred. Benefits are based upon the Plan’s provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan’s procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO re-pricing;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

**10.01B Timing of Claim Decisions**

Upon receiving a Clean Claim, the Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:
1. **Pre-service Non-urgent Care Claims.**
   a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

2. **Concurrent Claims:**
   a. **Plan Notice of Reduction or Termination.** If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
   b. **Request by Participant Involving Urgent Care.** If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
   c. **Request by Participant Involving Non-urgent Care.** If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

3. **Post-service Claims:**
   a. If the Participant has provided a Clean Claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

4. **Extensions – Pre-service Non-urgent Care Claims.** This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial
15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

5. **Extensions – Post-service Claims.** This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

### 10.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Plan Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan’s review procedures and the time limits applicable to the procedures;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant’s claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request.
9. In a claim involving urgent care, a description of the Plan’s expedited review process.

### 10.02 Appeal of Adverse Benefit Determinations

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The Plan provides for 2 levels of appeal following an Adverse Benefit Determination. The Participant has 180 days following an initial Adverse Benefit Determination to file an appeal of that determination, and 60 days following a second Adverse Benefit Determination to file an appeal of that determination. To initiate the appeal process, the Third Party Administrator must receive written request from the Participant, or an Authorized Representative of the Participant, with the proper form for review of an Adverse Benefit Determination.

### 10.02A Full and Fair Review of All Claims

The appeal process of this Plan provides a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
- Participants at least 60 days following receipt of a second Adverse Benefit Determination within which to appeal the determination;
Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant’s claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant’s right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances;

That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale; and

The first level of appeal will be the responsibility of the Third Party Administrator and will be decided within 30 days of the Third Party Administrator’s receipt of the request. The second level of appeal will be decided within 30 days of the Plan’s receipt of the request.

FIRST APPEAL LEVEL

10.02B  Requirements for Appeal
The Participant must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination.

For pre-service urgent care claims, if the Plan Participant chooses to initiate an appeal orally, the Plan Participant may telephone:

HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203
1-800-333-4731
Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant’s appeal must be addressed as follows:

1. For Pre-service Claims:

Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

HealthSCOPE Benefits
P.O. Box 2860
Little Rock, AR 72203
1-800-333-4731

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Participant;
2. The Employee/Participant’s social security number or alternate identification number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

10.02C Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan’s benefit determination on review within the following timeframes:

- **Pre-service Urgent Care Claims**: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-service Non-urgent Care Claims**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- **Concurrent Claims**: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- **Post-service Claims**: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
- **Calculating Time Periods**: The period of time within which the Plan’s determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.
10.02D  Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan’s adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the summary plan description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant’s claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Plan Participant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Plan Participant’s medical circumstances, will be provided free of charge upon request; and
7. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

10.02E  Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

10.02F  Decision on Review to be Final
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Second Appeal Level

A.  Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan’s Adverse Benefit Determination regarding the first appeal, the Participant has 60 days to file a second appeal of the denial of benefits. The Participant again is entitled to a “full and fair review” of any denial made at the first appeal, which means the Participant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Participant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

B.  Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Participant of the Plan’s Benefit Determination on review within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

C. Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan’s response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Participant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

D. Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

E. Decision on Second Appeal to be Final
If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within 3 years after the Plan’s Claim review procedures have been exhausted. Any action with respect to a fiduciary’s breach of any responsibility, duty or obligation hereunder must be brought within 3 years after the date of service.

10.03 Appointment of Authorized Representative
A Participant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Participant’s medical condition to act as the Participant’s authorized representative without completion of this form. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

10.04 Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Participant whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Participant must comply with this requirement as a necessary condition to coverage.

10.05 Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Participant whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

10.06 Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent’s Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

10.06A Assignments
Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for
determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

10.06B Non U.S. Providers
Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a “Non U.S. Provider”) are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non U.S. Provider;
2. The Participant is responsible for making all payments to Non U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

10.06C Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan’s terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan.
and agree to submit claims for reimbursement in strict accordance with their State’s health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party’s act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan’s Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider’s misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

10.06D Medicaid Coverage
A Participant’s eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Participant. Any such benefit payments will be subject to the State’s right to reimbursement for benefits it has paid on behalf of the Participant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

10.06E Limitation of Action
A Participant cannot bring any legal action against the Company or the Third Party Administrator to recover reimbursement until 90 days after the Participant has properly submitted a request for reimbursement as described in this section and all required reviews of the Participant’s claim have been completed. If the Participant wants to bring a legal action against the Company or the Third Party Administrator, he/she must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third Party Administrator.

A Participant cannot bring any legal action against the Company or the Third Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third Party Administrator he/she must do
so within 3 years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third Party Administrator.
ARTICLE XI
COORDINATION OF BENEFITS

11.01 Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

11.02 Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan’s benefits will be excess to, whenever possible:

a) Any primary payer besides the Plan;
b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker’s compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

11.04 Allowable Expenses.
“Allowable Expenses” shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with Section 10.06A herein, this Plan’s Allowable Expenses shall consist of the Plan Participant's responsibility, if any, after the Other Plan has paid but shall in no event exceed the Other Plan’s Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

11.05 “Claim Determination Period”
“Claim Determination Period” shall mean each calendar year.

11.06 Effect on Benefits:

11.06A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the plan's Allowable Expenses. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:
1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

11.06B Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;
2. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
   a. When the parents are separated or divorced, and the parent with the 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 determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
   b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child; and

4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

11.07 Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

11.08 Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

11.09 Right of Recovery
In accordance with section 10.06C, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such
payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see 10.06C above for more details.
ARTICLE XII
MEDICARE

12.01   Applicable to Active Employees and Their Spouses Ages 65 and Over
An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

12.02   Applicable to All Other Participants Eligible for Medicare Benefits
To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled “Coordination of Benefits”). The Participant will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the Provider accepts assignment with Medicare, covered expenses will not exceed the Medicare-approved expenses.

12.03   Applicable to Medicare Services Furnished to End Stage Renal Disease (“ESRD”) Plan Participants Who Are Covered Under This Plan
If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.
ARTICLE XIII
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

13.01 Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

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

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

13.02 Subrogation

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

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

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

4. If the Plan Participant(s) fails to file a claim or pursue damages against:
a) The responsible party, its insurer, or any other source on behalf of that party;
b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) Any policy of insurance from any insurance company or guarantor of a third party;
d) Worker’s compensation or other liability insurance company; or
e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

13.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)’ recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

13.04 Excess Insurance

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

The Plan’s benefits shall be excess to:

   a) The responsible party, its insurer, or any other source on behalf of that party;
   b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) Any policy of insurance from any insurance company or guarantor of a third party;
   d) Worker’s compensation or other liability insurance company; or
   e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or
other benefit payments, and school insurance coverage.

13.05 Separation of Funds

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

13.06 Wrongful Death

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

13.07 Obligations

1. It is the Plan Participant(s)’ obligation at all times, both prior to and after payment of medical benefits by the Plan:
   
   a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights;
   
   b) To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
   
   c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   
   d) To do nothing to prejudice the Plan’s rights of subrogation and reimbursement;
   
   e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
   
   f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

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

3. The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)’ cooperation or adherence to these terms.

13.08 Offset

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

13.09 Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

13.10 Language Interpretation

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

13.11 Severability

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

14.01 Applicable Law
This is a self-funded benefit plan, funded with employee and/or employer contributions. This plan is subject to Federal law and the laws of the state of Virginia, when applicable.

14.02 Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Participants have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

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

14.04 Fraud
The following actions by any Participant, or a Participant’s knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Participant is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Participant of the Plan;
2. Attempting to file a claim for a Participant for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

14.05 Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

14.06 No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

14.07 Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan. The amount of the Participant’s contribution (if any) will be determined from time to time by the Plan Administrator.
14.08  **Right to Receive and Release Information**
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

14.09  **Written Notice**
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

14.10  **Right of Recovery**
In accordance with 10.06C, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See 10.06C above for full details.

14.11  **Statements**
All statements made by the Company or by a Plan Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Plan Participant.

Any Plan Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Plan Participant may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

14.12  **Protection Against Creditors**
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

14.13  **Unclaimed Self-Insured Plan Funds**
In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable law(s).
ARTICLE XV
MEDICAL BENEFITS

15.01 Medical Benefits
Subject to the Plan’s provisions, limitations and exclusions, the following are covered major medical benefits:

1. Abortion. Expenses incurred directly or indirectly as the result of an abortion;
2. Acupuncture. Expenses for acupuncture when used as an anesthetic agent for a covered surgical procedure;
3. Allergy Services. Charges related to the Treatment of allergies;
4. Ambulance. Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient Confinement;
5. Ambulatory Surgical Center. Services of an Ambulatory Surgical Center for Medically Necessary care provided;
6. Anesthesia. Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
7. Birthing Center. Services of a Birthing Center for Medically Necessary care provided within the scope of its license;
8. Blood and Plasma. Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
9. Chemotherapy. Charges for chemotherapy/radiation;
10. Chiropractic Care. Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;
11. Dental. Emergency repair due to Injury to sound natural teeth, if the repair is made within 3 months from the date of the Injury (unless otherwise required by applicable law), excision of lesions and incision of accessory sinus, mouth, salivary glands or ducts;
12. Diagnostic Tests; Examinations. Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures. Laboratory tests which are included in an office visit charge must be rendered at the same time and the same place of service as the office visit;
13. Durable Medical Equipment. Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:
   a. Any purchases without its advance written approval;
   b. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment”;
14. Foot Disorders. Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);
15. Genetic Testing. Includes diagnostic testing of genetic information and counseling when Medically Necessary due to family history or complications of current or past pregnancy;

16. Glaucoma. Treatment of glaucoma, cataract Surgery and one set of lenses (contacts or frame-type);

17. Hearing Exams and Aids. Charges for hearing exams and hearing aids as limited in the Summary of Medical Benefits;

18. Home Health Care. Charges by a Home Health Care Agency:

   a. Registered Nurses or Licensed Practical Nurses;
   b. Certified home health aides under the direct supervision of a Registered Nurse;
   c. Registered therapist performing physical, occupational or Speech Therapy;
   d. Physician calls in the office, home, clinic or Outpatient department;
   e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Plan Participant that would have been provided in the Hospital, but not including Custodial Care; and
   f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

   NOTE: Transportation services are not covered under this benefit;

19. Hospice Care. Charges relating to Hospice Care, provided the Plan Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:

   a. Room and Board for Confinement in a Hospice;
   b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
   c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
   d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
   e. Home health aide services;
   f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
   g. Medical social services by licensed or trained social workers, Psychologists or counselors;
   h. Nutrition services provided by a licensed dietitian; and
   i. Bereavement counseling, which is a supportive service provided by the Hospice team to Plan Participants in the deceased’s Family after the death of the Terminally Ill person, to assist the Plan Participants in adjusting to the death. Benefits will be payable if the following requirements are met:

      (1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Plan Participant under the Plan; and
      (2) Charges for such services are Incurred by the Plan Participants within 6 months of the Terminally Ill person’s death.

   The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission;

20. Hospital. Charges made by a Hospital for:

   a. Inpatient Treatment

      (1) Daily Semi-Private Room and Board charges;
(2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
(3) General nursing services; and
(4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board

b. Outpatient Treatment

(1) Emergency room;
(2) Treatment for chronic conditions;
(3) Physical Therapy treatments;
(4) Hemodialysis; and
(5) X-ray, laboratory and linear therapy;

21. Mastectomy. The Federal Women’s Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

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; and
c. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with you and your attending Physician;

22. Medical Supplies. Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics;

23. Morbid Obesity. Charges for morbid obesity which is defined as a BMI of 40 or greater, or a BMI of 35 or greater in conjunction with a severe co-morbidity such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction. Includes initial lap band placement, lap band adjustment, gastric bypass, or gastric stapling. Reversal of surgical treatment is not covered;

24. Newborn Care. Hospital and Physician nursery care for Newborns who are natural children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the mother’s coverage, and the mother’s Deductible and coinsurance provisions will apply;

a. Hospital routine care for a Newborn during the child’s initial Hospital Confinement at birth; and
b. The following Physician services for well-baby care during the Newborn’s initial Hospital Confinement at birth:
   (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
   (2) Circumcision.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby’s coverage;

25. Nursing Services. Services of a Registered Nurse or Licensed Practical Nurse;
26. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility;

27. **Oral Surgery.** Oral Surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;

28. **Osseous Surgery.** Charges for osseous Surgery;

29. **Pathology Services.** Charges for Pathology Services;

30. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility;

31. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations;

32. **Pregnancy Expenses.** Under the Newborns’ and Mothers’ Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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). In no event will an “attending provider” include a plan, hospital, managed care organization, or other issuer. Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the “Summary of Benefits” and this section, and subject to the same maximums;

33. **Preventive Care.** Charges for preventive care services such as office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, colonoscopy, cholesterol tests, x-rays, laboratory blood tests, hearing exam, vision exam and immunizations/flu shots;

34. **Private Duty Nursing.** Private duty nursing (outpatient only);

35. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;

36. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

37. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician’s written treatment plan;

38. **Second Surgical Opinions.** Charges for second surgical opinions;

39. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Plan Participant is confined;
40. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Sickness or Injury, excluding Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;

41. **Sterilization.** Charges related to sterilization procedures, excluding reversal;

42. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

   a. Multiple procedures adding significant time or complexity will be allowed at:

      (1) 100% of the full Usual and Customary Fee value for the first or major procedure;

      (2) 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;

   b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;

   c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, and Customary Fee value for the type of surgery performed;

   d. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal surgery, performed during a single operative session;

43. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;

44. **Temporomandibular Joint Disorder.** Charges for the diagnosis and non-surgical treatment of, or in connection with, temporomandibular joint disorders;

45. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:

   a. Bone marrow;
   b. Heart;
   c. Lung;
   d. Heart and lung;
   e. Liver;
   f. Pancreas;
   g. Kidney; and
   h. Cornea.

   In addition, the Plan will cover any other transplant that is not Experimental.

   Covered expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered expenses include:

   a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
   b. Services and supplies furnished by a Provider; and
   c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.
Center of Excellence is required for Network benefits. Transportation and lodging is covered in connection with use of a Center of Excellence up to $10,000 per transplant if the Center of Excellence is more than 100 miles away from the Participant’s residence. Reimbursement will be $0.23/mile for transportation and $50 per night per person for lodging up to a maximum of $100 per night.

15.02 Psychiatric and Substance Abuse Benefits
The Plan will provide benefits for intermediate levels of care for mental health conditions and substance abuse disorders in parity with medical or surgical care of the same level. For instance, if the Plan provides benefits for a skilled nursing or rehabilitation facility for medical or surgical treatment, the Plan will provide equal benefits for intensive outpatient therapy, partial hospitalization or residential treatment. Contact the customer service number on the back of the member ID card for more information.

15.02A Inpatient Benefits
Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Semi-private hospital Room and Board;
2. Miscellaneous facility charges on days a Room and Board charge is covered;
3. Individual psychotherapy;
4. Group psychotherapy;
5. Psychological testing;
6. Family counseling; and

The benefits above are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital.

15.02B Outpatient Benefits
Subject to the limitations contained in the Summary of Benefits, the Plan will pay covered expenses for:

1. Individual psychotherapy;
2. Group psychotherapy;
3. Psychological testing;
4. Family counseling;
5. Convulsive therapy treatment; and
6. Prescription drugs or medicines for the treatment of mental illness or chemical dependency.

15.03 Exclusions
Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in Article VII, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. Acupuncture. Charges relating directly or indirectly to acupuncture, except as provided herein;
2. Adoption. Charges for adoption expenses;
3. Braces. Charges for replacement braces;
4. Complications. Charges for complications of a non-covered surgery or treatment;
5. Consultations. Consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
7. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or home health care except as specifically provided herein;

8. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

9. **Exercise Programs.** Charges for exercise programs;

10. **Gambling Addiction.** Charges related to gambling addiction;

11. **Gender Reassignment Surgery.** Expenses related to a gender reassignment surgery or treatment of sexual dysfunction not related to organic disease;

12. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness, except as provided herein;

13. **Hospital Admission.** Charges for non-emergency hospital admission on a Friday or Saturday;

14. **Hypnosis.** Expenses related to the use of hypnosis;

15. **Implants.** Charges for penile implants or removal of breast implants or other prosthetic implants;

16. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency drugs such as Viagra™, in-vitro fertilization, surrogate mother, donor eggs;

17. **Music Therapy.** Charges for music therapy;

18. **Obesity.** Expenses related to obesity, unless related to morbid obesity and covered herein;

19. **Oral Surgery.** Oral Surgery or dental treatment, except as specifically provided in the Plan;

20. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;

21. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist’s charge, and other supportive devices for the feet;

22. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;

23. **Pre-Marital Exams.** Charges for pre-marital exams;

24. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses;

25. **Smoking Cessation.** Charges for smoking cessation;

26. **Sterilization.** Charges for surgical sterilization reversal;

27. **Surrogacy.** Charges related to surrogacy;

28. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein;
29. **Visual Acuity.** Charges for visual acuity testing;

30. **Vitamins.** Vitamins.

15.04 **Cost Containment**

15.04A **Pre-Certification Procedures**
The Inpatient Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Inpatient Hospital care is needed, it is the Participant’s responsibility to call the pre-certification department at its toll-free number, which is 1-800-333-4731. The review process will continue, as outlined below, until the Participant is discharged from the Hospital. **Pre-certification is required for Inpatient admission to skilled nursing facilities, convalescent or rehabilitation facilities unless otherwise stated in this document.**

**Urgent Care or Emergency Admissions:**
If a Participant needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant should follow the Physician’s instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient; and
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date.

The Plan does not require the Participant to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, so there are no “Pre-service Urgent Care Claims” under the Plan. The Participant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

**Non-emergency Admissions:**
For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant’s attending Physician to obtain information and to discuss the specifics of the admission request. An on-line expert system that features state-of-the-art, widely accepted clinical review criteria is used to effectively guide the review process. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board-certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

15.04B **Pre-Certification Penalty**
The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department of any service as required in the section entitled “Pre-Certification Procedures,” allowed charges will be reduced by $300. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.
15.04C  Alternate Course of Treatment

Certain types of conditions, such as spinal cord Injuries, cancer, AIDS or premature births, may require long-term, or perhaps lifetime, care. The claims selected will be evaluated as to present course of treatment and alternate care possibilities.

If the Plan Administrator should determine that an alternate, less expensive, course of treatment is appropriate, and if the attending Physician agrees to the alternate course of treatment, all Medically Necessary expenses stated in the treatment plan will be eligible for payment under the Plan, subject to the applicable lifetime benefit set forth in this Plan, even if these expenses normally would not be eligible for payment under the Plan. In the event the Participant and the attending Physician select a more expensive course of treatment, coverage under the Plan will be based upon the charge allowed for the alternate, less expensive, course of treatment.

15.04D  Pre-Surgical Approval

The Plan recommends that a pre-determination of benefits be obtained prior to the following Surgical procedures, since they are usually Cosmetic Surgery or not Medically Necessary. These procedures include, but are not limited to:

1. Abdominoplasty;
2. Blepharoplasty;
3. Breast reduction or enlargement;
4. Dermabrasion;
5. Facial or nasal reconstruction;
6. Gastric bypass;
7. Gender reassignment surgery;
8. Lipectomy;
9. Penile implant;
10. Scar revision; or
11. Any Experimental or research procedures which are not generally accepted medical practice.

Because of the broad range of Surgical procedures available and under development, if a Participant is scheduled to undergo any questionable procedure, he or she should contact the Third Party Administrator for further information.
ARTICLE XVI
DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Deductible per Participant</th>
<th>$50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum benefit per calendar year for Class 1, 2, 3 and 4 Services</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

Does not apply to Participants under age 18.

<table>
<thead>
<tr>
<th>Covered Dental Expenses:</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1 Services (Preventive Care, no Deductible)</td>
<td>100%</td>
</tr>
<tr>
<td>Class 2 Services (Repair and Restoration)</td>
<td>80%</td>
</tr>
<tr>
<td>Class 3 Services (Major Dental Repair)</td>
<td>50%</td>
</tr>
<tr>
<td>Class 4 Services (Orthodontics)</td>
<td>50%</td>
</tr>
</tbody>
</table>

Charges are limited to Usual and Customary Fees.

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each calendar year toward covered expenses for Class 2, 3 and 4 services. Once the Deductible is satisfied, additional covered expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this Article.

16.01 Covered Expenses
The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary Fees.

Class 1 Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than twice per benefit period;
2. Periapical x-rays, as required, and bitewing x-rays, but not more than twice per benefit period;
3. Full mouth x-rays, but not more than twice per benefit period;
4. Panoramic x-rays, but not more than twice per benefit period;
5. Sealants for Dependent Children under age 15, once per tooth every 4 years;
6. Topical application of fluoride for Dependent Children under age 14, but not more than twice per benefit period; and
7. Space maintainers (not made of precious metals) that replace prematurely lost teeth and adjustments made within 6 months of installation.

Class 2 Services (Repair and Restoration)

1. All Medically Necessary x-rays;
3. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth. Gold foil restorations are not eligible;
4. Simple extractions;
5. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
6. Labs;
7. Oral Surgery;
8. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
9. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
10. Periodontal examinations, treatment and surgery; and
11. Consultations.
**Class 3 Services (Major Dental Repair)**
Prosthodontic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 12 months, unless otherwise required by applicable law.

1. Inlays, gold fillings, crowns, and initial installation of full or partial dentures or fixed bridgework to replace one or more natural teeth;
2. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
   a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
   b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 12 months;
3. Periodontal scaling;
4. Re-lines;
5. Post and core;
6. Stainless steel crowns; and
7. Dental implants.

**Class 4 Services (Orthodontics)**

1. Preliminary study, including cephalometric radiographs, diagnostic casts and treatment plan;
2. Interceptive, interventive or preventive orthodontic services;
3. Fixed and removable appliance placement, and active treatment per month after the first month; and
4. Extractions in connection with orthodontic services.

**16.02 Exclusions and Limitations**
The following exclusions and limitations are in addition to those set forth in the Articles entitled “General Limitations and Exclusions,” and “Summary of Benefits.”

1. **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
2. **Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records;
3. **After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses incurred for the following procedures will be payable as though the coverage had continued in force:
   a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
   b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
   c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;
4. **Broken Appointments.** For charges for broken or missed dental appointments;
5. **Cosmetic.** Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply.
to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;

6. **Crowns.** For crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting;

7. **Education.** Charges for instruction in oral hygiene, plaque control or diet;

8. **Excess Charges.** Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;

9. **Experimental.** Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;

10. **Government Provided.** Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay;

11. **Hygiene.** For oral hygiene, plaque control programs or dietary instructions;

12. **Immediate Relative.** Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Plan Participant requiring treatment. “Immediate relative” means spouse, child, brother, sister or parent of the Plan Participant, whether by birth, adoption or marriage;

13. **Miscellaneous.** The Plan does not cover any charge, service or supply which is:

   a. For treatment other than by a Dentist or Physician, except:
      (1) Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
      (2) Non-experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;
   b. For local infiltration anesthetic when billed for separately by a Dentist;
   c. For personalization or characterization of dentures or veneers or any cosmetic procedures or supplies;
   d. For oral hygiene or dietary instruction;
   e. For a plaque control program (a series of instructions on the care of the teeth);
   f. For periodontal splinting;
   g. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
   h. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
   i. For replacement of a lost, missing or stolen prosthetic device;
   j. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
   k. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
   l. Charges for missed appointments or completion of claim forms;
   m. Covered under the “Medical Benefits” Article of the Plan; and
   n. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;

14. **Missing Appliances.** Charges for replacement of lost, missing or stolen appliances or prosthetic devices;
15. **More Expensive Course of Treatment.** In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure;

16. **No Coverage.** Services or supplies for which charges are incurred at a time when no coverage is in force for that person, or for which charges are incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated;

17. **No Legal Obligation.** Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a Treatment Plan;

18. **No Listing.** For services which are not included in the list of covered dental services;

19. **Not Necessary.** Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;

20. **Not Recommended.** Charges for services or supplies which are not recommended and approved by a Dentist or Physician;

21. **Occupational.** Charges for dental care which results from any employment;

22. **Orthognathic Surgery.** For surgery to correct malpositions in the bones of the jaw;

23. **Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;

24. **Replacements.** Charges for replacement made within five years after the last placement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge. This exclusion is waived if replacement is needed because the appliance, crown, inlay, onlay or bridge, while in the oral cavity, is damaged beyond repair due to Injury sustained by the Plan Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury;)

25. **Self-inflicted.** Charges for care, treatment, services and supplies needed as a result of intentionally self-inflicted Injury or Sickness;

26. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee;

27. **Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic; and

28. **War/Riot.** Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any Country; or voluntary participation in a riot.

**16.03 Pre-determination of Dental Benefits**
If a Participant’s proposed course of treatment reasonably can be expected to involve dental charges of $1,000 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However,**
approval is not required prior to treatment. Any pre-determination of dental benefits is provided only as a convenience to the Participant.

If requested, the Plan Administrator or Third Party Administrator will notify the Employee, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. The pre-determination is not a guarantee of payment or approval of a benefit. After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.
ARTICLE XVII
PRESCRIPTION DRUG BENEFITS

<table>
<thead>
<tr>
<th>Covered Prescription Drug Expenses:</th>
<th>Participating Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy – 34-Day Supply:</td>
<td></td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for generic</td>
<td>$5 Copay</td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for formulary name brands</td>
<td>$30 Copay</td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for non-formulary name brands</td>
<td>$45 Copay</td>
</tr>
<tr>
<td>Mail Order – 90-Day Supply:</td>
<td></td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for generic</td>
<td>$10 Copay</td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for formulary name brands</td>
<td>$60 Copay</td>
</tr>
<tr>
<td>Copayment, per prescription or refill, for non-formulary name brands</td>
<td>$90 Copay</td>
</tr>
<tr>
<td>Specialty Pharmacy:</td>
<td>$115 Copay</td>
</tr>
<tr>
<td>Must be used after 1 fill at retail pharmacy.</td>
<td></td>
</tr>
</tbody>
</table>

Participating pharmacies (“Participating Pharmacies”) have contracted with the Plan to charge Participants reduced fees for covered Drugs. Cigna Pharmacy Management is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, Cigna Home Delivery, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayment is applied to each charge and is shown on the Summary of Benefits, above. The copayment amount is not counted toward any out-of-pocket maximums under the Plan.

17.01 Covered Expenses
The following are covered under the Plan:

1. **Acne Control.** Accutane and Retin A;
2. **Bee Sting Kits.** Charges for EPI PEN and Ana-Kit;
3. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
4. **DESI Drugs.** Charges for DESI Drugs;
5. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over-the-counter, and glucose test strips, when prescribed by a Physician;
6. **Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector);
7. **Impotency.** A charge for impotency medication, including Viagra™;
8. **Injectables.** A charge for injectables;
9. **Prescription Contraceptives.** Prescription contraception and contraception-related services;

10. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

11. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches;

12. **Steroids.** Anabolic steroids.

**17.02 Limitations**
The benefits set forth in this Article will be limited to:

1. **Dosages.**
   a. With respect to the Pharmacy Option, any one prescription is limited to a 34-day supply; and
   b. With respect to the Mail Order Option, any one prescription is limited a 90-day supply.

2. **Refills.**
   a. Refills only up to the number of times specified by a Physician; and
   b. Refills up to one year from the date of order by a Physician.

**17.03 Exclusions**
In addition to the General Exclusions set forth in Article VII, the following are not covered by the Plan:

1. **Administration.** Any charge for the administration of a covered Drug;

2. **Allergy Sera.** Charges for allergy sera;

3. **Anorexiants.** Anorexiants (weight-loss drugs);

4. **Blood and Blood Plasma.** Charges for Blood and Blood Plasma;

5. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;

6. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;

7. **Excluded Items.** Any charge excluded under the Articles entitled “General Limitations and Exclusions,” or “Summary of Benefits”;

8. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;

9. **Fertility Agents.** Charges for fertility agents;

10. **Growth Hormones.** Charges for growth hormones;

11. **Immunizations.** Immunization agents or biological sera;

12. **Immunologicals.** Charges for Immunologicals (vaccines);
13. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;

14. **Investigational Use Drugs.** A Drug or medicine labeled “Caution – limited by Federal law to investigational use;”

15. **Medical Devices and Supplies.** Charges for legend and over-the-counter medical devices and supplies;

16. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;

17. **Non-Insulin Syringes/Needles.** Charges for non-insulin syringes and needles;

18. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;

19. **Over-the-counter Drugs.** Charges for over-the-counter drugs;
   a. Class V Drugs;
   b. Diagnostics;
   c. Pre-natal vitamins; and
   d. Vitamins;

20. **Rogaine.** Charges for Rogaine (topical minoxidil);

21. **Vitamins.** Vitamins, except pre-natal vitamins.
ARTICLE XVIII
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Fairfax County Water Authority Health Plan (referred to herein as “we,” “our” or the “Plan”) is required under federal law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

• Your privacy rights with respect to your protected health information (“PHI”);
• The Plan’s duties with respect to your PHI;
• Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and
• The person or office to contact for further information about the Plan’s privacy practices.

SECTION I
NOTICE OF PHI USES AND DISCLOSURES

As explained in this Notice, the Plan and its business associates generally may use or disclose your PHI for treatment, payment or health care operations without your consent or authorization. The Plan and its business associates also are permitted to disclose your PHI to other persons or entities pursuant to and in compliance with a valid authorization from you, pursuant to your agreement, or as otherwise permitted or provided for by applicable law.

Upon your request, the Plan and its business associates generally also are required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI also may be required by the Secretary of the Department of Health and Human Services in order to investigate or determine compliance with the privacy regulations.

Uses and Disclosures for Treatment, Payment and Health Care Operations
The Plan and its business associates may use or disclose PHI without your consent, authorization, or opportunity to agree or object, in order to carry out treatment, payment and health care operations. The Plan, however, can not use or disclose PHI that is genetic information for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits). The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law. The following definitions apply for this purpose:

Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist, so that the orthodontist may request and obtain your dental X-rays from the treating dentist.

Payment includes, but is not limited to, actions relating to coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement activities, efforts to review competence or qualifications of health care professionals, and underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging medical reviews, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general
administrative activities. For example, the Plan may use your claims information to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in you or your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services.

Other Uses and Disclosures for Which Consent, Authorization or the Opportunity to Object is Not Required
Use and disclosure of your PHI is also allowed without your consent, authorization or request in the following circumstances:

1. when required by law and the use or disclosure complies with and is limited to the relevant requirements of such law;
2. when permitted for public health activities and purposes. Such uses and disclosures may include, but are not limited to, disclosures to public health or governmental entities authorized by law to collect or receive information for the purpose of preventing or controlling disease; disclosures to public health authorities or governmental agencies authorized by law to receive reports of child abuse or neglect; disclosures to persons subject to the Food and Drug Administration to report adverse events, product defects, and to facilitate product recalls. PHI also may be disclosed to an employer for this reason, but subject to certain conditions;
3. when authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless we reasonably believe that such disclosure would cause a risk of serious harm;
4. when required by public health agencies for oversight activities authorized by law. Such uses and disclosures may include, but are not limited to, disclosures required by civil, administrative or criminal investigations, proceedings or actions, activities necessary for the appropriate oversight of the health care system, and other activities necessary for the appropriate oversight of government benefit programs;
5. when required for judicial or administrative proceedings, including disclosures in response to a subpoena, court order or pursuant to a discovery request provided that certain conditions are met;
6. when required or permitted by law for law enforcement purposes including, but not limited to, disclosures pursuant to legal process; disclosures for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; and/or disclosures relating to individuals suspected to be a victim of crime under certain circumstances;
7. when required by a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosures may be made to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent;
8. when required for research purposes, subject to certain conditions;
9. when consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat;
10. when required for specialized governmental functions under certain conditions;
11. when authorized by and to the extent necessary to comply with Workers’ Compensation or other similar programs established by law.
We also may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you, and may disclose protected health information to the sponsor of the Plan as permitted by law.

**Except as otherwise indicated in this Notice, uses and disclosures of your PHI will be made only with your written authorization, subject to your right to revoke such authorization.**

**Uses and Disclosures that Require Your Written Authorization**
The Plan and its business associates generally must obtain an authorization from you for the use or disclosure of psychotherapy notes. Your authorization is not required for uses or disclosures of such notes that are necessary for treatment, payment or health care operations, including the use, by the originator of the psychotherapy notes, for treatment, or the use or disclosure of such information for training purposes as provided by law. We may also use and disclose such notes to defend against litigation or other legal proceeding brought by you or on your behalf.

Except as otherwise provided by law, the Plan and its business associates also must obtain an authorization from you for any use or disclosure of PHI for marketing purposes. The Plan also will not accept any remuneration, direct or indirect, for the use or disclosure of your health information without your authorization.

**Other Uses and Disclosures that Require that You be Given an Opportunity to Agree or Disagree Prior to the Use or Release**
Unless otherwise required or permitted by law or by your authorization, disclosure of your PHI to family members, other relatives and your close personal friends is allowed, only if the information is directly relevant to the family or friend’s involvement with your care or payment for that care, and you have been given an opportunity to object and have not objected.

**SECTION II
INDIVIDUAL RIGHTS**

**Right to Request Restrictions on PHI Uses and Disclosures**
You may request that the Plan and its business associates restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, but the Plan is not required to agree to your request. If, however, you pay the full cost of a health care item or service (without any Plan payment), you may request that a business associate (or healthcare provider) not disclose that item or service to the Plan for payment or health care operations purposes (but not for carrying out treatment), and your request must be honored.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211. The Privacy Officer is the Manager of Security and Safety, or any other person so designated by the General Manager. The Plan and its business associates will accommodate reasonable requests to receive communications of PHI by alternative means or at alternate locations.

**Right to Inspect and Copy PHI**
You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan or any of its business associates maintains the PHI (including obtaining electronically maintained information in an electronic format). This right is limited to enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan, as well as records used to make decisions about individuals. You also may request that copies of your PHI be sent to another entity or person, so long as that request is clear, specific and directs where the copies are to be sent. In limited cases, the Plan does not have to agree to your request. Any charge that is assessed to you for these copies, if any, must be reasonable and based on Plan costs. The following definitions apply for this purpose:

“PHI” or “Protected Health Information” includes all individually identifiable health information transmitted or maintained by the Plan regardless of form.
“Designated Record Set” includes the medical and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not a part of a designated record set.

“Electronic health record” includes health-related information collected for health care clinicians and staff.

A response to a request for PHI will be provided within 30 days if the information is maintained onsite. A single 30-day extension is allowed if the Plan or a business associate is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan or the Secretary of the U.S. Department of Health and Human Services.

**Right to Amend PHI**

You have the right to request the Plan or a business associate to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You must make any amendment request in writing, stating within the request the reasons that you believe support the requested amendment.

The Plan or business associate has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan or business associate is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included in any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of your PHI in your designated record set. Requests for amendment of PHI in a designated record set should be made to the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211.

**The Right to Receive an Accounting of PHI Disclosures**

You are entitled to receive an accounting of disclosures of your PHI by the Plan or a business associate during the 6 years prior to the date of your written request, except for disclosures made: (1) to you about your own PHI; (2) to persons involved in your care or for notification purposes required by law; (3) for national security purposes; (4) to others pursuant to your authorization; (5) to law enforcement as permitted by law; or (6) as part of a limited data set. In addition, if the Plan maintains electronic health records, you may (to the extent required by law) receive an accounting of disclosures made for treatment, payment, or health care operations contained in such records, during the 3 years before the date of your request. For this purpose, an “electronic health record” is generally a record that contains health-related information for an individual which is gathered and consulted by authorized health care clinicians and staff.

If the accounting cannot be provided by the Plan or business associate within 60 days, an additional 30 days is allowed so long as you are given a written statement of the reasons for the delay and the date that the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

**The Right to Receive a Paper Copy of This Notice Upon Request**

If you received this Notice on a service or benefits website maintained by the Plan, you have the right to request and
obtain a paper copy of this Notice by contacting the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211.

A Note About Personal Representatives
You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order appointing the person as conservator or guardian; or
- An individual who is the parent of a minor child.

The Plan’s disclosure of PHI of an unemancipated minor to a parent, guardian or other person acting in loco parentis for such unemancipated minor, is subject, at all times, to applicable provisions of state and federal law, including applicable case law.

The Plan retains discretion to deny access to PHI to a personal representative in order to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

SECTION III
THE PLAN’S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide participants and beneficiaries with notice of its legal duties and privacy practices.

This Notice is effective beginning February 17, 2010, and the Plan is required to comply with the terms of this Notice. The Plan, however, reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to participants and beneficiaries for whom the Plan still maintains PHI.

Any revised version of this Notice will be distributed to all affected participants and beneficiaries, in writing, within 60 days of the effective date of any material change to the uses or disclosures, the individual’s rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard
When using or disclosing PHI or when requesting PHI from another covered entity, the Plan and its business associates will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. In general, until regulations are issued, disclosure is to be limited to limited data set information unless more information is needed.

The minimum necessary standard, however, will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to you or on your behalf;
- Uses or disclosures made pursuant to an authorization from you;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- Uses or disclosures that are required by law; and
- Uses or disclosures required for the Plan’s compliance with legal regulations.

This Notice does not apply to de-identified information. De-identified information is information that does not identify an individual and information for which there is no reasonable basis to believe it can be used to identify an individual.
In addition, the Plan and its business associates may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. This information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with applicable law.

**Notice of Breaches of Unsecured PHI**
You will receive notice from the Plan of any unauthorized access, use or disclosure (a “breach”) of your unsecured PHI within 60 days of the Plan’s discovery of the breach. If the breach affects more than 500 individuals in a state or other jurisdiction, notice will also be provided through one or more prominent media outlets in the area. The notice will describe what happened (including the date of the breach and date the breach was discovered), the type of PHI involved, steps you should take to protect yourself, and steps the Plan will take to mitigate any harmful effects from the breach and to protect against future breaches.

**SECTION IV**
**YOUR RIGHT TO FILE A CLAIM WITH THE PLAN OR THE HHS SECRETARY**

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

**SECTION V**
**WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION**

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, Office of the General Manager, Fairfax Water, 8570 Executive Park Avenue, Fairfax, VA 22031 or by calling 703-289-6211.

**Conclusion**
PHI use and disclosure by the Plan is regulated by a federal law known as the Health Insurance Portability and Accountability Act (“HIPAA”). You can find these rules at 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.
ARTICLE XIX
HEALTH INFORMATION PRIVACY AND SECURITY

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA’s standards for privacy of individually identifiable health information (the “privacy standards”), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
(2) Modifying, amending or terminating the Plan.

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

Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes
Except as described under “Disclosure of Summary Health Information to the Plan Sponsor” above or under “Disclosure of Certain Enrollment Information to the Plan Sponsor” below or under the terms of an applicable individual authorization, The Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document, certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
(2) Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
(4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
(5) Make available PHI in accordance with section 164.524 of the privacy standards;
(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;
(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services (“HHS”), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;
(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
(10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:
   (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such
individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

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

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan documents have been amended to incorporate the above provisions; and
2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.
HIPAA SECURITY PRACTICES

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

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

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

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

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

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.