THIS IS AN AMENDED AND RESTATED

HEALTH BENEFIT PLAN

FOR

OAKLAND COUNTY

PPO PLAN 1

Effective Date of Amended and Restated Plan:

January 1, 2019

Group Numbers: G-962 and G-962-01

SUMMARY OF MATERIAL MODIFICATIONS #4

HEALTH BENEFIT PLAN FOR OAKLAND COUNTY (PPO PLAN 1)

The Health Benefit Plan has been amended. The changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of January 1, 2022, unless specifically stated otherwise.

1. The following provision will be added to the **BENEFITS** section of the Plan document:

   The Total Maximum Out-of-Pocket do not include any drug manufacturer's assistance.

2. The following provision will be added to the **BENEFITS** section of the Plan document:

   The Plan does not require certification for emergency services.

3. In the introductory section of the **SCHEDULE OF MEDICAL BENEFITS**, the second note will be revised to read as follows:

   As required by the No Surprises Act, if a Covered Person receives services in the following situations, the services will be paid at the In-Network benefit level: (1) emergency care; (2) transportation by air ambulance; or (3) nonemergency care at an In-Network facility provided by an Out-of-Network Physician or laboratory, unless the Covered Person provides informed consent.

   Additionally, if a Covered Person receives eligible treatment at an In-Network facility, any charges for the following will be paid at the In-Network benefit level, even if provided by an Out-of-Network Physician or laboratory: (1) anesthesiology, pathology, radiology, or neonatology; (2) assistant surgeons, hospitalists, or intensivists; (3) diagnostic services (including radiology and laboratory services); and (4) items and services provided by an Out-of-Network Physician or laboratory if there was no In-Network Physician or laboratory that could provide the item or service at the In-Network facility.

4. In the introductory section of the **SCHEDULE OF MEDICAL BENEFITS** section of the Plan document, the final note will be revised to read as follows:

   Certification is recommended for all Inpatient Hospital admissions, select surgical procedures, and some Outpatient procedures. Please see the "Utilization Review Program" subsection for more information such as program requirements.

5. The following will be added to the **UTILIZATION OF IN-NETWORK PROVIDERS** section of the Plan document:

A Covered Person who is a Continuing Care Patient will receive a notice that the Covered Person may elect to receive transitional care. If the Covered Person timely notifies the Plan of the Covered Person's need for transitional care, charges from the In-Network Provider that moved Out-of-Network will continue to be paid at the In-Network benefit level (and subject to the same terms and conditions that apply In-Network) for a period of 90 days or, if earlier, the date that the Covered Person is no longer a Continuing Care Patient. This 90-day period begins on the date that the Covered Person receives the notice regarding transitional care. A Covered Person who is a Continuing Care Patient is not eligible for transitional care if the In-Network Provider is removed from the network for failure to meet applicable quality standards or for fraud.

6. The following two changes will be made to the **UTILIZATION REVIEW PROGRAM** section of the Plan document:

A. The following new provision will be added:

The Plan does not require certification for emergency services.

B. The ***OUTPATIENT SERVICE CERTIFICATION*** subsection will be deleted in its entirety and replaced with the following:

SELECT SURGICAL PROCEDURE AND OUTPATIENT SERVICE CERTIFICATION

If a Covered Person's treatment includes any of the following services, the treatment should be reviewed before its inception, regardless of whether or not the treatment is in lieu of hospitalization:

A. Select surgical procedures*
B. Durable Medical Equipment, including, but not limited to, breast pumps, if the purchase price or forecasted total rental cost is $2,500 or more
C. Home Health Care
D. Custom-made Orthotic or Prosthetic Appliance if the purchase price is $2,500 or more
E. Outpatient oncology treatment (chemotherapy or radiation therapy)
F. Outpatient infusion or injection of select products*

*The list of the select surgical procedures and the list of infusion or injection products requiring certification can both be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card.

In addition to the standard certification requirement for the Outpatient infusion or injection of select products as included in the service list above, the Plan will require those infusions and injections to be administered in a home, office, or free-standing infusion center setting. The Plan will not generally cover the infusion or injection of select products at an Outpatient Hospital facility, and the Covered Person will have to pay for the full cost of that care, unless the Plan Administrator determines that any of the following exceptions apply: (1) treatment is medically appropriate in a facility setting rather than a home, office, or free-standing infusion center setting; (2) the medication is subject to limited distribution and is available only at certain facilities; or (3) the Covered Person would have to travel more than 50 miles from his or her home to receive services in an office or free-standing infusion center setting, or the provider is a Plan-approved site of service. A Covered Person can call the telephone number on the front of his or her health plan identification card to confirm whether a provider is a Plan-approved site of service.

To facilitate claims processing, a provider of service should call the telephone number on the front of the Covered Person's health plan identification card as soon as possible before receiving the above-listed services, but in no event later than two business days after the services were rendered. No penalty will generally be assessed for noncompliance with the certification requirement. However, the Plan will not cover the infusion or injection of select products at an Outpatient Hospital facility unless one of the exceptions above apply.

7. In the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT – *COVERED CHARGES*** section of the Plan document, the *Ambulances* provision will be revised to read as follows:

Ambulances

Charges for professional ambulance service (ground or air) to or from a facility where eligible, Medically Necessary care or treatment may be rendered or may have been rendered when the Covered Person's condition mandates such transportation. Benefits are provided for air ambulance transportation if the Plan Administrator determines that the Covered Person's condition, the type of service required for the treatment of the Covered Person's condition, and the type of facility required to treat the Covered Person's condition justify the use of air ambulance instead of another means of transport (that is, no other method of transportation is appropriate, including emergency ground transport).

NOTE: If the Covered Person could have been treated at a facility nearer than the one to which he or she was transported, payment for ground or air ambulance service is limited to the rate for the distance from the point of pickup to that nearer facility. If a determination is made to order transport by air ambulance, but ground ambulance transport would have sufficed, payment for the air ambulance transport is based on the amount payable for ground ambulance transport.

8. In the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT – *COVERED CHARGES*** section of the Plan document, the special continuity of care provision in the *Obesity Treatment* benefit that allowed for certain treatments started before January 1, 2019 to continue to be eligible for Plan coverage per the terms of the prior provision will be discontinued. All charges for Medically Necessary treatment of Obesity will now only be covered if the charges meet the coverage terms and requirements stated in the current *Obesity Treatment* provision and no further exceptions will be permitted.

9. In the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT – *COVERED CHARGES*** section of the Plan document, the *Rehabilitative Therapies* provision will be deleted in its entirety and will be replaced with the following provision:

   Rehabilitative Services

   Charges incurred for Physical Therapy, Occupational Therapy, or Speech Therapy treatment or services rendered by a licensed physical therapist, a licensed occupational therapist, or a licensed speech therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury. Covered charges include health care services that assist a Covered Person in restoring or improving skills and functions that have been lost or impaired because of Illness, Injury, or congenital anomaly. However, services for psychosocial dysfunction, idiopathic developmental delays unrelated to an Illness, learning disabilities, Functional Nervous Disorders, socioeconomic differences, and the aging process are not covered.

10. In the **GENERAL PLAN EXCLUSIONS AND LIMITATIONS** section of the Plan document, the *Free School-Provided Special Education Services* provision will be revised to read as follows:

    Free School-Provided Special Education Services

    Charges for services available to physically or mentally impaired individuals where a school is required to provide those services free of charge (e.g., rehabilitative services or special education).

11. The following exclusion will be added to the **GENERAL PLAN EXCLUSIONS AND LIMITATIONS** section of the Plan document:

    Infusion or Injection of Select Products at an Outpatient Hospital Facility

    Charges for the infusion or injection of select products at an Outpatient Hospital facility unless the Plan Administrator has determined that (1) treatment is medically appropriate in a facility setting rather than a home, office, or free-standing infusion center setting; (2) the medication is subject to limited distribution and is available only at certain facilities; or (3) the Covered Person would have to travel more than 50 miles from his or her home to

receive services in an office or free-standing infusion center setting, or the provider is a Plan-approved site of service.

12. In the **ELIGIBILITY AND PARTICIPATION – SCHEDULE FOR ELIGIBILITY AND PARTICIPATION** section of the Plan document, the ***ACTIVE COVERAGE ELIGIBILITY REQUIREMENTS*** subsection will be revised to read as follows:

ACTIVE COVERAGE ELIGIBILITY REQUIREMENTS

In order to be eligible to participate in this Plan, an individual must satisfy the following requirements:

A. Be currently employed by the Employer and can be identified in one of the following employment classifications:

   a. Working in Full-Time Employment for 40 or more hours per week.

   b. Working in a Part-Time Eligible Position (as this term is further defined in the Employer's policies).

   Under no circumstances will an individual be allowed to participate in the Plan until he or she is working in Full-Time Employment or classified by the Employer to be working in a Part-Time Eligible Position.

B. Be a Dependent of an Employee who is eligible for and enrolled in the Employer's Medicare Supplemental coverage because of End Stage Renal Disease (ESRD). These individuals may be subject to special rules for eligibility, enrollment, and contributions as described in the Employer's written policies. In the event of a conflict between this document's provisions and the Employer's written policies permitting this coverage, the Employer's policies will rule.

NOTES:

1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll for coverage under the Plan as both a Participant and as a Dependent. However, any claims submitted by such individuals would be subject to the Plan's usual Coordination of Benefits provision.

2. As permitted under Health Care Reform and detailed in the Employer's written policies, the Employer will use the Look-Back/Stability Period Safe Harbor method to determine the eligibility of an Employee who does not work in Full-Time Employment or a Part-Time Eligible Position to participate in the Plan. Contact the Employer for more information.

13. In the **ELIGIBILITY AND PARTICIPATION – SCHEDULE FOR ELIGIBILITY AND PARTICIPATION** section of the Plan document, the ***PARTICIPANT EFFECTIVE DATE*** subsection will be revised to read as follows:

PARTICIPANT EFFECTIVE DATE

Participation in the Plan will start for new Employee applicants on the first of the month following the date on which they meet the Active Coverage Eligibility Requirements stated above. Participation in the Plan will start for new Retiree applicants on the first of the month following the date on which they meet the Retiree Coverage Eligibility Requirements stated above. Both Employee and Retiree applicants must also meet the requirements described in the Participant Enrollment section.

14. In order to correctly communicate the intent and administration of the Plan that has been in place since March 1, 2020, the **MISCELLANEOUS** – ***CONFORMITY WITH LAW*** provision of the Plan document will be revised to read as follows:

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

The Plan shall comply with guidance issued by the U.S. Department of Labor and the U.S. Department of Treasury (Joint Notice, Disaster Relief Notice 2020-01, and Disaster Relief Notice 2021-01) to extend the claim filing and appeal deadlines mandated by the Plan in response to the COVID-19 pandemic, from March 1, 2020 until the earlier of (a) one year from the date that the Covered Person was first eligible for relief, (b) 60 days after the announced end of the National Emergency Period (the end of the Outbreak Period), or (c) December 31, 2021. In no event will an Outbreak Period deadline extension exceed one year.

15. The following two new defined terms will be added to the **DEFINITIONS** section of the Plan document:

CONTINUING CARE PATIENT

The term "Continuing Care Patient" means a Covered Person who (1) is undergoing a course of treatment for a serious and complex condition from an In-Network Provider; (2) is undergoing a course of institutional or Inpatient care from an In-Network Provider; (3) is scheduled to undergo non-elective surgery from an In-Network Provider, including receipt of postoperative care from the In-Network Provider with respect to the non-elective surgery; (4) is pregnant and undergoing a course of treatment for the Pregnancy from the

In-Network Provider; or (5) is or was determined to be terminally ill and is receiving treatment for the terminal Illness from the In-Network Provider.

NO SURPRISES ACT

The term "No Surprises Act" refers to the provisions in MCL 333.24501 *et seg.* and Sections 2799A-1 and 2799A-2 of the PHSA, as amended.

16. In the **DEFINITIONS** section of the Plan document, the *OCCUPATIONAL THERAPY*, *PHYSICAL THERAPY*, and *SPEECH THERAPY* definitions will be deleted in their entirety and replaced with the following:

OCCUPATIONAL THERAPY

The term "Occupational Therapy" means the specialized group of therapy services provided by or under the direction of a licensed occupational therapist that assist a Covered Person in restoring or improving skills and functions that have been lost or impaired because of Illness, Injury, or congenital anomaly. Services may include, but are not limited to, evaluation, treatment, and consultation.

PHYSICAL THERAPY

The term "Physical Therapy" means the specialized group of therapy services provided by or under the direction of a licensed physical therapist that assist a Covered Person in restoring or improving skills and functions that have been lost or impaired because of Illness, Injury, or congenital anomaly. Services may include, but are not limited to, massage, manipulation, therapeutic exercises, cold, heat (including shortwave, microwave, and ultrasonic diathermy), hydrotherapy, electric stimulation, and light.

SPEECH THERAPY

The term "Speech Therapy" means the specialized group of therapy services provided by or under the direction of a licensed speech therapist that assist a Covered Person in restoring or improving skills and functions that have been lost or impaired because of Illness, Injury, or congenital anomaly. Services may include, but are not limited to, evaluation of motor speech skills, expressive and receptive language skills, writing and reading skills, social interaction skills, and cognitive functioning; and the development of speech, listening, and conversation skills.

17. In the **DEFINITIONS** section of the Plan document, the *TELEMEDICINE* definition will be revised to read as follows:

TELEMEDICINE

The term "Telemedicine" means medical care provided through electronic or telephonic communications. Telemedicine care is typically rendered as an alternative to a traditional

office visit and provides "on demand" medical care as well as remote evaluations/monitoring by phone, computer, or mobile device. The Plan may also cover other types of medical care provided through electronic or telephonic communications, and when eligible, such services will be paid the same as any other Illness (cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered).

18. In the **DEFINITIONS** section of the Plan document, the following new note will be added to the *USUAL AND CUSTOMARY* definition:

NOTE: For claims that are subject to the No Surprises Act, the No Surprises Act governs the calculation of the payment amount by the Plan for purposes of determining both (1) the Covered Person's cost-sharing requirement, and (2) the total payment, net of the Covered Person's cost-sharing requirement, to the Physician or other provider. For example, these amounts may be calculated using the Qualifying Payment Amount, which is generally the median of the Plan's contracted rate with In-Network Providers for the same item or service in the same geographic area. The payment amount for other Out-of-Network claims may be calculated in this same manner, subject to the Plan Administrator's discretion.

All other provisions of the Plan shall remain in effect and unchanged.

OAKLAND COUNTY
G-962
G-962-01

SUMMARY OF MATERIAL MODIFICATIONS #3

HEALTH BENEFIT PLAN FOR OAKLAND COUNTY (PPO PLAN 1)

The Health Benefit Plan has been amended. The changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of September 1, 2021.

1. In the **SCHEDULE OF MEDICAL BENEFITS** section of the Plan document, the ***AUTISM SPECTRUM DISORDER SERVICES*** benefit will be revised to read as follows:

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
AUTISM SPECTRUM DISORDER SERVICES		
▪ *Autism Spectrum Disorder Treatment (including, but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)*	100%	85%
▪ *Applied Behavior Analysis (ABA) Treatment*	100%	100%

2. In the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT – *COVERED CHARGES*** section of the Plan document, the *Behavioral Care* provision will be revised to read as follows:

Behavioral Care

Charges for Behavioral Care including services provided by a Physician or by counselors or therapists who are certified or licensed as social workers, Psychologists, or Clinical Nurse Specialists and who have a master's degree or its equivalent in psychology, counseling education/counseling psychology, social work, or psychiatric nursing. Charges rendered by a provider for applied behavior analysis (ABA) treatment will also be eligible for coverage when a diagnosis of autism has been made by a Physician, a treatment plan for the Covered Person has been developed by a board certified behavior analyst, and such treatment is performed by a board certified behavior analyst or a provider working under the supervision of a board certified behavior analyst. Addictions Treatment care may also

be rendered by an Addictions Treatment counselor who is certified and licensed by the state in which he or she practices.

The Covered Person's diagnosis must be specifically classified by reference to the most current version of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

The care must fall into one of the following categories:

1. Individual psychotherapy
2. Family counseling for members of the Covered Person's Family
3. Group therapy
4. Psychological testing by a Psychologist
5. Electroshock therapy
6. Autism spectrum disorder services

Behavioral Care services may be rendered in any combination of the following intensities:

1. Inpatient admission.

2. Partial Hospitalization care (a day program consisting of at least five sessions per day for at least five days per week). A Partial Hospitalization program is an alternative to an Inpatient treatment program. The treatment categories of a Partial Hospitalization treatment program may include treatment categories that are provided in a Physician's office, Outpatient Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.

3. Intensive Outpatient care (a day program consisting of fewer than five sessions per day for fewer than five days per week). The treatment categories of an Intensive Outpatient treatment program may include treatment categories that are provided in a Physician's office, Outpatient Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.

4. Outpatient therapy (periodic visits ranging from one session per week to one session per month).

Unless administered in an Inpatient or Outpatient health care facility setting, prescription drugs prescribed for Behavioral Care purposes are <u>not</u> covered under this benefit or any other benefit of the Plan.

NOTE: Care provided in a home or a residential, subacute, transitional, or institutional facility, on a temporary or permanent basis, is excluded where any of the following are unavailable:

1. Twenty-four-hour access to a Physician
2. Twenty-four-hour on-site licensed nursing staff
3. Twenty-four-hour skilled observation and medication administration

The costs of living and being cared for in transitional living centers, non-licensed programs, or therapeutic boarding schools as well as the costs for care that is custodial, designed to keep a Covered Person from continuing unhealthy activities, or typically provided by community mental-health-services programs are excluded.

All other provisions of the Plan shall remain in effect and unchanged.

OAKLAND COUNTY
G-962
G-962-01

SUMMARY OF MATERIAL MODIFICATIONS #2

HEALTH BENEFIT PLAN FOR OAKLAND COUNTY (PPO PLAN 1)

The Health Benefit Plan has been amended. The changes affecting the Plan are set forth in this Summary of Material Modifications and are effective as of March 1, 2020, unless specifically stated otherwise below.

1. The following benefit will be added to the **SCHEDULE OF MEDICAL BENEFITS** section of the Plan document:

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
CORONAVIRUS DISEASE OF 2019 (COVID-19) TESTING AND PREVENTIVE MITIGATION SERVICES		
▪ *Eligible Charges Incurred March 1, 2020 Through the Expiration of the Applicable Emergency Period*	100%	100%
▪ *All Other Eligible Charges Incurred Outside of the Time Frame Specified Above*	Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered	

NOTES:

1. In accordance with federal law, the Plan will provide coverage for the testing of and preventive mitigation efforts for COVID-19 without any cost-sharing provisions such as Deductibles (if any) or co-payments for claims incurred beginning on March 1, 2020 and ending upon the expiration of the applicable emergency period as outlined in the Families First Coronavirus Response Act (FFCRA), as amended by the Coronavirus Aid, Relief and Economic Security (CARES) Act, as well as any later laws that amend either of those Acts directly or indirectly, in whole or in part.

2. Eligible charges for treatment of COVID-19 or any related complications caused by or related to the virus are not eligible for coverage under this benefit. Instead, when eligible for Plan coverage, such charges will be paid the same as any other Illness. Cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered.

2. The following benefit will be added to the list of ***COVERED CHARGES*** in the **COMPREHENSIVE MEDICAL EXPENSE BENEFIT** section of the Plan document:

COVID-19 Testing and Preventive Mitigation Services

In accordance with the FFCRA, as amended by the CARES Act (as well as any later laws that amend either of those Acts directly or indirectly, in whole or in part), charges for the testing of and preventive mitigation efforts for COVID-19 as follows:

1. An in vitro diagnostic test for the detection of SARS-CoV-2 virus or for the diagnosis of COVID-19, as well as the administration of such a test if the test meets one of the following requirements:

   a. The test is approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act (FFDCA).

   b. The developer of the test has requested or intends to request emergency use authorization under the FFDCA.

   c. The test is developed in and authorized by a state that has notified the U.S. Department of Health and Human Services (HHS) of its intention to review tests intended to diagnose COVID-19.

   d. The test has been determined by HHS to be appropriate in guidance (e.g., serology testing to detect antibodies against the virus that causes COVID-19).

2. Items and services such as influenza tests and blood tests, as well as the Physician's exam fee (when applicable) furnished during an immediate care visit, an emergency room visit, or an Outpatient provider visit (including charges for an in-person office visit, a drive-through screening and testing site, or a Telemedicine e-visit) if the visit results in an order for or administration of an in vitro diagnostic test as described above, but only to the extent the items and services relate to the furnishing or administration of the diagnostic test or to the evaluation of the individual for purposes of determining the need of the individual for such a test.

3. Other services intended to mitigate or prevent the disease (including vaccinations, when available).

3. In the **ELIGIBILITY AND PARTICIPATION** - ***EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION*** section of the Plan document, a new Employer-provided extension shall be added to the Plan for Employer-mandated schedule reductions implemented for reasons related to the COVID-19 situation as follows:

COVID-19 Extension of Participation for Extension Events Commencing March 1, 2020 through December 31, 2020	*Through the end of the Calendar Year in Which the Leave Began*

NOTE*:* The Long-Term Disability Leave Extension of Participation (except to the extent that it is also a Family and Medical Leave Act of 1993 [FMLA] extension of participation) will be offset against the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation. Any other Employer-provided extension of participation, including the Short-Term Disability Leave Extension of Participation and COVID-19 Extension of Participation, will be in addition to the length of a COBRA extension of participation.

4. The first paragraph of the **EXTENSIONS OF PARTICIPATION** section of the Plan document will be revised to read as follows:

A Participant may have participation extended under the Employer-provided extensions specified in the Schedule for Eligibility and Participation, under the FMLA, or under COBRA. A Long-Term Disability Leave Extension of Participation will typically coincide with the commencement of a COBRA extension of participation (if applicable) and will offset the length of a COBRA extension of participation; however, in the event that this Employer-provided extension of participation ever runs concurrently with an FMLA extension of participation, the COBRA extension of participation will proceed after the FMLA extension of participation ends. Any other Employer-provided extension of participation, including a Short-Term Disability Leave Extension of Participation and COVID-19 Extension of Participation, will apply before a COBRA extension of participation and will be in addition to the length of a COBRA extension of participation.

5. The following subsection will be added to the **EXTENSIONS OF PARTICIPATION** − ***EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION*** section of the Plan document:

COVID-19 Extension of Participation for Extension Events Commencing March 1, 2020 through December 31, 2020

Participation for a Participant and any eligible Dependents continues if the following conditions are all met:

A. The Participant was employed by the Employer in benefits-eligible employment on February 29, 2020.

B. The Participant was working in either Full-Time Employment or in a Part-Time Eligible Position according to the Oakland County Employer policy (e.g., the Participant was working in either a full-time or part-time eligible-for-benefits capacity, and was enrolled for Plan coverage).

C. During the timeframe that begins on March 1, 2020 and continues through December 31, 2020, the Employer temporarily reduces the Participant's hours below the minimum required for Plan participation because of reasons related to the COVID-19 situation.

For Participants that meet the requirements stated within this provision, this extension of participation will allow Plan coverage to continue through the end of the Calendar Year in which the extension begins if the Employer places the Participant on a COVID-19 Extension of Participation during the timeframe that begins on March 1, 2020 and continues through December 31, 2020. This extension of participation begins when the Participant is placed on a reduced schedule by the Employer and terminates at the end of the 2020 Calendar Year or the expiration of the extension, whichever occurs first.

6. In the **MISCELLANEOUS** section of the Plan document, the following paragraph will be added to the ***CONFORMITY WITH LAW*** provision:

In accordance with guidance issued by the U.S. Department of Labor and the U.S. Department of Treasury (Joint Notice and Disaster Relief Notice 2020-01), applicable deadlines mandated by the Plan will be extended in response to the current COVID-19 pandemic from March 1, 2020 until 60 days after the announced end of the National Emergency Period (Outbreak Period). Specifically, the Plan shall disregard the Outbreak Period when calculating these deadlines.

7. In the **DEFINITIONS** section of the Plan document, the *ACTIVE EMPLOYMENT* definition will be revised to read as follows:

ACTIVE EMPLOYMENT

The term "Active Employment" means the Participant is an Employee who is eligible for Plan benefits and not terminated from employment with Oakland County. A Participant shall be deemed to be working in Active Employment to the limited extent required by the FFCRA for each day of paid sick leave (beginning April 1, 2020, and only to the extent that HIPAA requires the Plan to consider the Participant to be working in Active Employment).

All other provisions of the Plan shall remain in effect and unchanged.

OAKLAND COUNTY
G-962
G-962-01

SUMMARY OF MATERIAL MODIFICATIONS #1

HEALTH BENEFIT PLAN FOR OAKLAND COUNTY

The Health Benefit Plan has been amended. The change affecting the Plan is set forth in this Summary of Material Modifications and is effective as of March 18, 2020.

The Plan considers Telemedicine e-visits to be eligible for coverage on generally the same basis as any other office visit; however, In-Network Telemedicine e-visits will now be covered under the Plan at 100% with the Deductible waived (no co-payment will apply). The term "Telemedicine" means medical care provided through electronic or telephonic communications. Telemedicine care is typically rendered as an alternative to a traditional office visit and provides "on demand" medical care as well as remote evaluations/monitoring by phone, computer, or mobile device.

All other provisions of the Plan shall remain in effect and unchanged.

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INTRODUCTION

OAKLAND COUNTY has established the PPO1 Health Benefit Plan for Oakland County as a self-funded employer group health plan in order to provide certain benefits for certain Employees, Retirees, and their eligible Dependents. Oakland County executes this amended and restated document, including any future addenda, to re-establish this Plan for the exclusive benefit of the participating Employees, Retirees, and their Dependents. This document is also considered to be the Summary Plan Description and is intended to explain the Plan. Please read this document carefully and acquaint your Family with its provisions.

This Plan, and any Employer-offered plans that are provided as an alternative to coverage under this Plan, shall together constitute a single plan for purposes of the nondiscrimination requirements of Section 105(h)(2) of the Code.

This Plan is not an arrangement whereby each enrollee is covered by insurance. Instead, the Employer funds claims. Insurance may be purchased to protect the Employer against large claims. However, if for some reason the medical expenses that are eligible for payment under the Plan are not paid, the individuals covered by the Plan could ultimately be responsible for those expenses.

PLAN ADMINISTRATOR

The Plan Administrator is **OAKLAND COUNTY**. The Plan Administrator shall have the authority and discretion to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Plan Administrator retains all rights to administer the Plan, regardless of the Claim Administrator's delegated responsibilities as specified throughout this Plan document.

CLAIM ADMINISTRATOR

The Claim Administrator of the Plan is **ASR HEALTH BENEFITS** (**ASR**). The Claim Administrator shall only have the responsibilities delegated to it in writing in an Administration Agreement or other written agreement.

The Claim Administrator processes claims and does not insure that any medical expenses of Covered Persons will be paid.

OTHER BASIC INFORMATION ABOUT THE PLAN

1.	*Plan Name*:	PPO1 Health Benefit Plan for Oakland County
2.	*Employer/Plan Sponsor/ Plan Administrator:*	Oakland County 2100 Pontiac Lake Road Building 41 West Human Resources Waterford, Michigan 48328-0440 (248) 858-5212 (or for Retirees: [248] 858-8215)

3.	*Employer Identification No.:*	38-6004876
4.	*Group Numbers:*	G-962 (Employees) G-962-01 (Retirees)
5.	*Type of Plan:*	Welfare Benefit Plan providing medical benefits
6.	*Claim Administrator:*	ASR Health Benefits P.O. Box 6392 Grand Rapids, Michigan 49516-6392 (616) 957-1751 or (800) 968-2449 www.asrhealthbenefits.com
7.	*Type of Administration:*	The Claim Administrator administers claims for benefits pursuant to a contract with the Plan Administrator.
8.	*Agent for Service of Legal Process:*	Manager of Human Resources Benefits Administration Division Oakland County 2100 Pontiac Lake Road Building 41 West Waterford, Michigan 48328-0440 For participating Employees, service of process may be made upon the Plan Administrator. For Retirees, service of process may be made upon the Retirement Administrator.
9.	*Effective Date of Amended and Restated Plan:*	January 1, 2019. The Plan has been periodically amended and restated, most recently as of January 1, 2014.
10.	*Plan Year:*	January 1 through December 31

***PLEASE NOTE*: THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION DESCRIBES THE CIRCUMSTANCES WHEN THE PLAN PAYS FOR HEALTH CARE. THERE MAY BE CIRCUMSTANCES WHEN YOU AND YOUR PHYSICIAN DETERMINE THAT HEALTH CARE THAT IS NOT COVERED BY THIS PLAN IS APPROPRIATE. REMEMBER THAT ALL DECISIONS REGARDING YOUR HEALTH CARE ARE UP TO YOU AND YOUR PHYSICIAN.**

NONDISCRIMINATION NOTICE

Oakland County complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oakland County

does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

To help people with disabilities and people whose primary language is not English, Oakland County provides free aids and services such as:

- Qualified interpreters, including sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Written information in other languages

If you need any of these services, call the Human Resources Department at (248) 858-0530.

If you believe that Oakland County has failed to provide these free aids and services or has discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Oakland County's Human Resources Department as follows:

Human Resources Department
Oakland County
2100 Pontiac Lake Road
Waterford, MI 48328
Telephone: (248) 858-0530

You can file a grievance in person, by mail, or by e-mail. If you need help filing a grievance, the Human Resources Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019 or TDD (800) 537-7697

Civil rights complaint forms are available at https://www.hhs.gov/ocr/filing-with-ocr/index.html.

IF YOU NEED LANGUAGE ASSISTANCE

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-248-858-0530.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-248-858-0530

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-248-858-0530。

ﺗﻨﺒﻴﻪ: ﺇﺫﺍ ﻛﻨﺖ ﺗﺘﺤﺪﺙ ﺑﻠﻐﺔ ﻓﺈﻥ ﺧﺪﻣﺎﺕ ﺍﻟﻤﺴﺎﻋﺪﺓ ﺍﻟﻠﻐﻮﻳﺔ ﻣﺘﺎﺣﺔ ﻟﻚ ﺑﺪﻭﻥ ﻣﻘﺎﺑﻞ. ﺍﺗﺼﻞ ﺑﺮﻗﻢ 1-248-858-0530

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-248-858-0530.

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-248-858-0530.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-248-858-0530 번으로 전화해 주십시오.

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-248-858-0530 ।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-248-858-0530.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-248-858-0530.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-248-858-0530.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-248-858-0530 まで、お電話にてご連絡ください。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-248-858-0530.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-248-858-0530.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-248-858-0530.

NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA, does not apply to this Plan. The fact that the Plan may, in some respects, conform to the requirements of ERISA, or include provisions often found in plans that are subject to ERISA, shall not be interpreted or construed to mean that the Plan is intended to comply with ERISA, or that Employees, Participants, Dependents, or beneficiaries have any rights under ERISA. The preceding statement also pertains to other federal laws that do not apply to the Plan.

HOW TO FILE A MEDICAL CLAIM

If the bill is not being submitted directly by the provider, please submit itemized copies of any bills that have been incurred to the Claim Administrator, ASR Health Benefits (ASR), via mail or e-mail as follows:

Mail: P.O. Box 6392, Grand Rapids, Michigan 49516-6392
E-mail: claimsubmit@asrhealthbenefits.com
Phone: (616) 957-1751 or (800) 968-2449

If the claim is for an Injury, additional information will be required in order to proceed with processing. You must provide information in writing, detailing how, when, and where the Injury was received. Failure to provide this information may delay the timely processing of the claim.

CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

All information will be reviewed promptly. The Plan Administrator or ASR may request missing or additional data if needed. The Plan Administrator or ASR reserves the right to require an original claim form or billing statement.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the diagnosis, the type of care or supply received, and the cost per item.

Generally, the provider of service (Hospital, Physician, laboratory, etc.) will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, ASR will, acting on behalf of the Plan Administrator, issue a check for the amount due and/or an "Explanation of Benefits." The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to ASR as soon as each bill is received, even if the Deductible (if applicable) has not yet been met. Please read this booklet before a claim occurs because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the Employer or ASR.

BENEFITS

Benefits are described and are subject to the terms and conditions set forth in the pages that follow. In-Network benefits are based on network-contracted rates, and Out-of-Network benefits are based on Usual and Customary charges.

SCHEDULE OF MEDICAL BENEFITS

IMPORTANT!!

1. **As detailed in this Schedule of Benefits, the Plan is designed to pay at different benefit levels based on the type of service rendered and whether this medical service or item has been categorized as "basic coverage" or "master medical coverage." Most Covered Expenses are considered to be "basic coverage" and would be subject to the "basic coverage" level of benefits. However, a few Covered Expenses (as designated below) have been set aside as "master medical coverage" and would be subject to the "master medical coverage" level of benefits.**

2. **If a Covered Person receives eligible treatment at an In-Network facility, any anesthesiology, pathology, or radiology**

charges will be paid at the In-Network benefit level, even if Out-of-Network Providers performed those services.

3. **If a Covered Person receives treatment from an Out-of-Network Provider and the Plan Administrator determines that treatment was not provided by an In-Network Provider for one of the reasons specified below, the claim may be adjusted to yield In-Network-level benefits:**

   a. **There was not access to a Qualified In-Network Provider located within a Reasonable Distance from the Covered Person's residence.**

   b. **It was not reasonable for the Covered Person to seek care from an In-Network Provider because of a Medical Emergency.**

   c. **A Covered Person traveled to a place where he or she could not reasonably be expected to know the location of the nearest In-Network Provider (if available).**

   The term "Qualified" as used above means having the skills and equipment needed to adequately treat the Covered Person's condition. The term "Reasonable Distance" as used above approximates a 50-mile radius.

4. **Certification is recommended for all Inpatient Hospital admissions and for some Outpatient procedures. Please see "Utilization Review Program" on page 16 for more information such as program requirements.**

BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
COMPREHENSIVE MEDICAL		
Deductible per Plan Year		
▪ *Basic Coverage (applies to all Covered Expenses, unless specifically stated otherwise)*	$0/Covered Person (In-Network and Out-of-Network basic coverage services combined) $0/Family (In-Network and Out-of-Network basic coverage services combined)	
▪ *Master Medical Coverage (applies to limited Covered Expenses as identified at the end of this schedule, unless specifically stated otherwise)*	$200/Covered Person (In-Network and Out-of-Network master medical coverage services combined) $400/Family (In-Network and Out-of-Network master medical coverage services combined)	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COMPREHENSIVE MEDICAL, cont.		
Benefit Percentage Paid		
▪ *Basic Coverage (applies to all Covered Expenses, unless specifically stated otherwise)*	100% (0% Coinsurance)	85% (15% Coinsurance)
▪ *Master Medical Coverage (applies to limited Covered Expenses as identified at the end of this schedule, unless specifically stated otherwise)*	90% after Deductible (10% Coinsurance)	75% after Deductible (25% Coinsurance)
Coinsurance Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses (includes Basic Coverage and Master Medical Coverage claims) per Plan Year (includes Coinsurance only)	$1,000/Covered Person (In-Network and Out-of-Network services combined) $1,000/Family (In-Network and Out-of-Network services combined)	
Total Maximum Out-of-Pocket for Comprehensive Medical Covered Expenses (includes Basic Coverage and Master Medical Coverage claims) per Plan Year (includes Deductible [if applicable], Coinsurance, and In-Network medical co-payments)	$4,125/Covered Person (In-Network and Out-of-Network services combined) $10,250/Family (In-Network and Out-of-Network services combined)	

NOTES:

1. The Deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan.

2. The Total Maximum Out-of-Pocket for medical services does not include expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, or are otherwise excluded under the

COMPREHENSIVE MEDICAL, cont.

provisions of the Plan. Prescription drug co-payments track toward a separate Prescription Drug Maximum Out-of-Pocket to the extent required by Health Care Reform (details about this separate Maximum Out-of-Pocket are not discussed in this Plan document; contact the Employer for more information). Once the Plan's Total Maximum Out-of-Pocket has been satisfied by any combination of Deductible (if applicable), Coinsurance, and In-Network medical co-payments paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year.

BASIC COVERAGE BENEFITS

NOTE: The "basic coverage" benefits identified below are <u>not</u> intended to be a comprehensive listing of the Plan's Covered Expenses. For more details on the items and services that the Plan considers to be Covered Expenses and generally subject to the "basic coverage" level of benefits, refer to the Comprehensive Medical Expense Benefit section beginning on page 17.

HOSPITAL	100%	85%
Hospital Certification	Recommended	Recommended
Room and Board	Network-contracted rate	Usual and Customary rate

EMERGENCY ROOM CARE

▪ *Physician's Fee for an Examination in the Emergency Room*	$100 co-payment* per visit, then 100%	Paid as In-Network

*The co-payment shall be waived if emergency room care is received as a direct result of an Accidental Injury or if the Covered Person is admitted as an Inpatient or on an observational basis from the emergency room.

▪ *All Other Charges Billed by the Physician in Connection with the Emergency Room Treatment*	100%	Paid as In-Network

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
EMERGENCY ROOM CARE, cont.		
▪ *Hospital's Fee for the Use of the Emergency Room*	100%	Paid as In-Network
▪ *All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit*	100%	Paid as In-Network
OUTPATIENT PHYSICIAN VISITS *(includes office visits, immediate care center visits, and Telemedicine e-visits)*		
▪ *Physician's Fee for an Examination*	$20 co-payment per visit, then 100%	$20 co-payment per visit, then 85%
▪ *All Other Charges Billed in Connection with the Examination*	Paid the same as any other Illness; cost-sharing provisions such as Deductibles (if any), Coinsurance, or co-payments may apply depending upon the type of service rendered	
DIABETIC SUPPLIES *(includes insulin, syringes, lancets, lancet devices, alcohol swabs, test strips, insulin pumps, glucose monitors, and other Medically Necessary diabetic supplies; Physician's prescription is required)*	90%	75%
ROUTINE PREVENTIVE CARE		
▪ *Physician's Fee for an Examination**	100%	Not covered
*The Plan applies specific frequency limitations to Routine exams, including well-baby and Routine child care visits. For more information on this benefit, see page 29 and reference the list of covered preventive care items and services available on the Claim Administrator's Website.		

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ROUTINE PREVENTIVE CARE, cont.		
▪ *FDA-Approved Contraceptive Methods for Women with Reproductive Capacity*		
Contraceptive Injections (includes both substance and administration charges)	100%	85%
All Other Contraceptives and Contraceptive-Related Physician Services	100%	100%
▪ *Sterilization Procedures for Women with Reproductive Capacity*	100%	85%
▪ *Routine Mammograms and Routine or Diagnostic Colonoscopies***	100%	85%
**The first mammogram performed for Routine screening purposes and the first colonoscopy, whether performed for Routine or diagnostic purposes, in any Plan Year will be paid under this benefit (subject to the applicable above-stated benefit percentage). All charges incurred in connection with a diagnostic mammogram or any subsequent Routine/diagnostic colonoscopies or Routine mammograms (or charges related to diagnostic mammograms or subsequent Routine/diagnostic colonoscopies or Routine mammograms) incurred in a Plan Year will not be covered under this benefit, but instead will be paid the same as any other Illness (subject to applicable Deductible, if any, and general benefit percentage).		
▪ *Rental or Purchase of Breastfeeding Equipment*	100%	85%
Maximum benefit paid for breast pumps per Covered Person per birth (applies to Out-of-Network services only)	Not applicable	$250

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ROUTINE PREVENTIVE CARE, cont.		
▪ *Routine Immunizations Administered at a Public Health Department (including any injection fee charge or other immunization-related charges)*	100%	100%
▪ *Routine Immunizations Administered in a Physician's Office (including any injection fee charge or other immunization-related charges), Routine X-Rays and Labs, and Other Routine Services*	100%	Not covered

NOTE: The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; Routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.

AUTISM SPECTRUM DISORDER SERVICES		
▪ *Autism Spectrum Disorder Treatment (including, but not limited to, Outpatient Physical Therapy, Speech Therapy, Occupational Therapy, nutritional counseling, and Behavioral Care)*	100%	85%

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
AUTISM SPECTRUM DISORDER SERVICES, cont.		
▪ *Applied Behavior Analysis (ABA) Treatment*	100%	100%
Maximum benefit paid for ABA treatment per eligible Covered Person per Plan Year (In-Network and Out-of-Network services combined)	$50,000	
NOTE: The Plan will consider charges for ABA treatment to be eligible for payment (subject to the annual dollar maximum stated above) until a Covered Person reaches the end of the Plan Year in which he or she turns age 26. Any ABA treatment charges billed for a patient who is older than this allowance will not be covered under this benefit or any other benefit of the Plan.		
CHIROPRACTIC CARE		
▪ *Physician's Fee for an Initial or Periodic Evaluation, Spinal Manipulations, and Therapy Treatments*	$20 co-payment per day, then 100%	$20 co-payment per day, then 85%
▪ *Diagnostic Spinal X-Rays*	100%	85%
Maximum number of chiropractic visits (for this purpose, a "visit" means all chiropractic services rendered by one provider in a day) allowed per Covered Person per Plan Year (In-Network and Out-of-Network services combined)	38	

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
MASTER MEDICAL COVERAGE BENEFITS **NOTE: The benefits listed below are intended to be a comprehensive listing of the Covered Expenses subject to the "master medical coverage" level of benefits. For more details on these benefits as well as "basic coverage" benefits, refer to the Comprehensive Medical Expense Benefit section beginning on page 17.**		
AMBULANCE TRANSPORTATION	90% after Deductible	Paid as In-Network
DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, AND ORTHOTICS	90% after Deductible	75% after Deductible
NOTE: Certain DME items are required by Health Care Reform to be covered under the Plan's Routine Preventive Care benefit. Accordingly, when such items are received from an In-Network Provider, these charges will be processed as a Routine Preventive Care expense and subject to no cost sharing. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card.		
PRIVATE DUTY NURSING	90% after Deductible	75% after Deductible

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth in the General Provisions section, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, this Plan shall be the primary plan and the automobile insurance shall be the secondary plan for purposes of paying benefits.

HEALTH CARE REFORM

The Plan complies with the insurance market-related provisions of Health Care Reform. The required provisions include the following:

A. The Plan allows eligible Dependent children to continue to participate in the Plan through the end of the Calendar Year in which the child's 26th birthday occurs.

B. The Plan will not impose an annual or Lifetime limit on the dollar value of an Essential Health Benefit.

C. Coverage will not be retroactively rescinded except as permitted by law, for example, in cases of fraud, intentional misrepresentation, or failure to timely pay required premiums for coverage. Notice that coverage will be retroactively rescinded must generally be provided 30 days before proceeding with the termination process.

D. The Plan will not impose a pre-existing condition limitation or exclusion on any otherwise eligible claim.

E. The Plan will not impose a waiting period for coverage that exceeds 90 calendar days, including weekends and holidays. Coverage under a group health plan must begin no later than the 91st day after an employee meets all of the plan's eligibility requirements.

F. This Plan option is not a grandfathered plan under Health Care Reform. Accordingly, the following additional insurance market reforms under Health Care Reform apply:

1. The Plan provides certain preventive care items and services without required Participant cost-sharing.

2. The Plan provides certain patient protections such as:

- The Plan does not currently require the designation of a Personal Care Physician (PCP). However, in the event that a Covered Person is ever required to designate a Personal Care Physician (PCP), the Covered Person may designate any participating PCP, including a Pediatrician, as the Covered Person's PCP.

- The Plan does not require a preauthorization or referral when a Covered Person seeks coverage for obstetric or gynecological care from an In-Network OB-GYN.

- The Plan does not require a preauthorization for emergency services.

- With respect to certain emergency services rendered in the emergency department of an Out-of-Network Hospital, the Plan does not impose a co-payment or Coinsurance percentage that is greater than the co-payment or Coinsurance percentage that would be assessed if the services had been performed in the emergency department of an In-Network Hospital.

3. Covered Persons are afforded additional rights with respect to internal appeals under the Plan and are provided with the opportunity to undergo a new external review procedure.

4. The Plan is required to cover certain charges associated with approved clinical trials.

5. The Plan is generally required to comply with out-of-pocket limits that are established by the federal government and may be adjusted annually.

GENERAL BENEFIT PROVISIONS

In order for the Plan to pay any benefits, all of the following requirements must be met:

A. An expense must be incurred by a Covered Person while this Plan is effective and the Covered Person participates in the Plan. Unless otherwise provided in the Plan, a Covered Expense, loss, charge, or claim is incurred on the date that services or materials are provided.

B. The Covered Person must follow the claim procedures of this Plan.

C. The benefit must be one of the benefits described in this Plan, including all causation limitations, Deductibles (if applicable), maximum limits and caps, benefit percentages, and any other payment limitations within the benefit.

D. The expense incurred by a Covered Person must be a Covered Expense payable under a benefit described in the Plan or a charge expressly covered by a benefit in the Plan.

E. The expense will be paid or reimbursed only to the extent that it is based on either a contracted schedule or on the Plan's Usual and Customary fee limitations and is submitted with appropriate procedural and diagnostic codes for the service(s) rendered.

F. The expense must not be excluded or in excess of a limitation as provided in the General Plan Exclusions and Limitations section.

G. The expense must not be payable or reimbursable by another plan whose coverage is primary to the coverage of this Plan, as provided in the Coordination of Benefits section.

If a change in the Covered Person's coverage that would increase or decrease any maximum benefit applicable to the Covered Person becomes effective in accordance with the terms of the Plan, that increase or decrease shall apply immediately.

UTILIZATION OF IN-NETWORK PROVIDERS

The Plan has entered into an agreement with a network of Physicians, Hospitals, and other medical providers (In-Network Providers) who have agreed to provide health care at discounted fees. For Covered Persons who use In-Network Providers, this option works in tandem with the traditional coverage under the Plan by giving those Covered Persons the opportunity to reduce their out-of-pocket expenses. If a Covered Person chooses to be treated by an In-Network Provider, payment of charges for eligible benefits under the Plan will be made at the corresponding percentage stated in the Schedule of Benefits and will be subject to the co-payment(s) stated in the Schedule of Benefits (however, as further explained in the Schedule of Benefits, in no event will a Covered Person be charged an In-Network co-payment if it would cause him or her to pay more than the Plan's Total Maximum Out-of-Pocket).

Covered Persons will be given the names of Physicians, Hospitals, and other medical providers available in their area who have agreed to be In-Network Providers. The network names are printed on the Covered Person's identification card, and a complete list of In-Network Providers participating in these networks can be viewed by visiting the networks' Website addresses. Covered Persons may also request a complete list of In-Network Providers from the Claim Administrator, which will be provided to Participants as a separate document free of charge.

Medical treatment is solely a decision between a Covered Person and their Physician. While the Plan may provide different levels of benefits depending on the Covered Person's choice of provider, neither the Plan Administrator nor the Claim Administrator endorses one licensed medical provider over another. Increased benefit levels applicable to In-Network Providers are based solely upon negotiated fees or discounts.

UTILIZATION REVIEW PROGRAM

HOSPITAL ADMISSION CERTIFICATION

If a Covered Person is scheduled for an Inpatient Hospital confinement, or is admitted to a Hospital on an observation basis, that Hospital stay should be reviewed before the admission.

To facilitate claims processing, a provider of service should call the telephone number on the front of the Covered Person's health plan identification card as soon as possible before a Hospital admission, but in no event later than two business days following the admission. No penalty will be assessed for noncompliance.

OUTPATIENT SERVICE CERTIFICATION

If a Covered Person's treatment includes any of the following services, the treatment should be reviewed before its inception, regardless of whether or not the treatment is in lieu of hospitalization:

A. Outpatient Physical Therapy
B. Outpatient Occupational Therapy
C. Outpatient Speech Therapy

D. Durable Medical Equipment, including, but not limited to, breast pumps, if the purchase price or forecasted total rental cost is $2,500 or more
E. Home Health Care
F. Custom-made Orthotic or Prosthetic Appliance if the purchase price is $2,500 or more
G. Outpatient oncology treatment (chemotherapy or radiation therapy)
H. Outpatient infusion or injection of select products*

*****The list of the select products requiring certification can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card.

To facilitate claims processing, a provider of service should call the telephone number on the front of the Covered Person's health plan identification card as soon as possible before receiving the above-listed services, but in no event later than two business days after the services were rendered. No penalty will be assessed for noncompliance with the certification requirement.

ADDITIONAL INFORMATION

Completion of these certification requirements does not guarantee payment. Payment is subject to the determination of eligibility and coverage based on the Plan's terms as indicated in this Plan document. If certification is denied, the Covered Person may appeal this decision, as described in the Appeal of Denial subsection of the Claims Procedure section.

ALTERNATIVE TREATMENT

The description of Covered Expenses under the Plan may be expanded in certain situations in order to provide the most appropriate and cost-effective level of care for the Covered Person. These alternative treatment benefits may be provided after review and consultation with both the Utilization Review Department and the Covered Person's Physician. Each situation shall be reviewed, and recommendations made, on a case-by-case basis. The Utilization Review Department cannot require a change in a Covered Person's level of care without the approval of the attending Physician. After alternative treatment is initiated, the Utilization Review Department shall monitor the care to ensure that the most appropriate level of care is maintained. This provision shall not increase any stated maximum benefits described in the Schedule of Benefits.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT

BENEFIT PERCENTAGE AND DEDUCTIBLE

Generally, the Plan will pay the percentage stated in the Schedule of Benefits for the amount stated in the Schedule of Benefits, except that the Covered Person or Family, not the Plan, must first pay the amounts necessary to satisfy any applicable Deductibles listed in the Schedule of Benefits. However, once the applicable Maximum Out-of-Pocket stated in the Schedule of

Benefits has been satisfied, the Plan will then pay 100% of Covered Expenses until the end of the Plan Year.

The Deductibles apply to the Covered Expenses listed in the Schedule of Benefits as "master medical coverage" each Plan Year. An individual Deductible need be satisfied only once per Plan Year, regardless of the number of Illnesses, except that once a Family has exceeded the Family Deductible, any remaining Deductibles for individuals within the Family need no longer be met. In no event shall the maximum Deductible for any one Covered Person exceed the amount stated in the Schedule of Benefits; no individual within a Family will be allowed to satisfy "extra" Deductibles in order to fulfill the Family Deductible. Claims incurred during the last three months of a Plan Year that were applied toward any Deductible will also be applied toward the satisfaction of Deductibles for the next Plan Year.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator may allocate the Deductible amount to any eligible charges and apportion the benefits to the Covered Person and any assignees. The allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COVERED CHARGES

In order to be eligible for benefits under this section, services a Covered Person actually receives must be administered or ordered by a Physician and be Medically Necessary for the diagnosis and treatment of an Illness or Injury, unless otherwise specifically covered.

NOTE: Some of the following provisions may conflict to some extent with the preventive care services required by Health Care Reform to be covered under this Plan as a Routine Preventive Care expense. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card. In the event a provision below conflicts with the provisions of the summary, the provisions of the summary will rule.

Covered charges include the following:

A. *Abortions*

Charges for all abortions, whether elective or Medically Necessary.

B. *Ambulances*

Charges for professional ambulance service (ground and/or air) to or from a facility where appropriate care or treatment may be rendered or may have been rendered when the Covered Person's condition mandates such transportation.

C. *Anesthesia*

Charges for the cost and administration of an anesthetic by a Physician, a Certified Registered Nurse Anesthetist, or a Certified Anesthesiologist Assistant

(CAA) who is practicing in a state that recognizes CAAs through licensure or delegatory authority.

D. *Behavioral Care*

Charges for Behavioral Care including services provided by a Physician or by counselors or therapists who are certified or licensed as social workers, Psychologists, or Clinical Nurse Specialists and who have a master's degree or its equivalent in psychology, counseling education/counseling psychology, social work, or psychiatric nursing. Charges rendered by a provider for applied behavior analysis (ABA) treatment will also be eligible for coverage when a diagnosis of autism has been made by a Physician, a treatment plan for the Covered Person has been developed by a board certified behavior analyst, and such treatment is performed by a board certified behavior analyst or a provider working under the supervision of a board certified behavior analyst. Addictions Treatment care may also be rendered by an Addictions Treatment counselor who is certified and licensed by the state in which he or she practices.

The Covered Person's diagnosis must be specifically classified by reference to the most current version of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

The care must fall into one of the following categories:

1. Individual psychotherapy
2. Family counseling for members of the Covered Person's Family
3. Group therapy
4. Psychological testing by a Psychologist
5. Electroshock therapy
6. Autism spectrum disorder services (subject to any benefit limitations and maximums stated in the Schedule of Benefits)

Behavioral Care services may be rendered in any combination of the following intensities:

1. Inpatient admission.

2. Partial Hospitalization care (a day program consisting of at least five sessions per day for at least five days per week). A Partial Hospitalization program is an alternative to an Inpatient treatment program. The treatment categories of a Partial Hospitalization treatment program may include treatment categories that are provided in a Physician's office, Outpatient Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.

3. Intensive Outpatient care (a day program consisting of fewer than five sessions per day for fewer than five days per week). The treatment categories of an Intensive Outpatient treatment program may include treatment categories that are provided in a Physician's office, Outpatient

Behavioral Care Facility, Behavioral Care Hospital Outpatient department, or an extension of a Behavioral Care Hospital.

4. Outpatient therapy (periodic visits ranging from one session per week to one session per month).

Unless administered in an Inpatient or Outpatient health care facility setting, prescription drugs prescribed for Behavioral Care purposes are not covered under this benefit or any other benefit of the Plan.

NOTE: Care provided in a home or a residential, subacute, transitional, or institutional facility, on a temporary or permanent basis, is excluded where any of the following are unavailable:

1. Twenty-four-hour access to a Physician
2. Twenty-four-hour on-site licensed nursing staff
3. Twenty-four-hour skilled observation and medication administration

The costs of living and being cared for in transitional living centers, non-licensed programs, or therapeutic boarding schools as well as the costs for care that is custodial, designed to keep a Covered Person from continuing unhealthy activities, or typically provided by community mental-health-services programs are excluded.

E. *Birthing Centers*

Charges for services and supplies furnished by a Birthing Center to an eligible Covered Person for prenatal care, delivery, and postpartum care rendered within 24 hours after delivery.

F. *Blood Processing*

Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

G. *Breast Reconstruction Following Mastectomy*

Charges for the following services related to breast reconstruction when performed in conjunction with a mastectomy:

1. Reconstruction of the breast on which the mastectomy has been performed.

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

3. Prostheses.

4. Treatment of physical complications of all stages of mastectomy, including lymphedema.

Coverage will be provided in a manner determined in consultation with the Covered Person and his/her attending Physician.

H. *Chiropractic Care*

Charges for the services of a Physician who is a chiropractor for the diagnosis and treatment of an Injury or Illness, and for custodial or maintenance care, are covered by this Plan to the extent that these charges do not exceed the benefit maximum(s) stated in the Schedule of Benefits. Eligible chiropractic services are limited to spinal manipulations, therapy treatments, diagnostic spinal X-rays, and office visits (initial and periodic evaluations).

Charges for support pillows, braces, or any other type of equipment recommended or prescribed by a chiropractor are not covered under the Plan. Chiropractic charges are not covered by any other benefit in this Plan.

I. *Clinical Trials*

Charges for Routine Patient Costs for items and services furnished to a Covered Person who has cancer or a Life-Threatening Condition and who is a Qualified Individual in connection with participation in an Approved Clinical Trial. The Plan will not deny such a Covered Person's participation in an Approved Clinical Trial or discriminate against such a Covered Person on the basis of his or her participation in an Approved Clinical Trial.

The following definitions apply for purposes of clinical trial coverage under the Plan:

1. The term "Approved Clinical Trial" means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Condition, as further described in Section 2709(d) of the Public Health Services Act.

2. The term "Life-Threatening Condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted, as described in Section 2709(e) of the Public Health Services Act.

3. The term "Qualified Individual" means a Covered Person who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other Life-Threatening Condition and where either the referring health care professional is a participating health care provider and has concluded that the individual's participation in the clinical trial would be appropriate based upon the individual meeting the trial protocol, or the individual provides medical and scientific information establishing that his or her participation in the

clinical trial will be appropriate based upon the individual meeting the trial protocol.

4. The term "Routine Patient Costs" means items and services consistent with the Plan's typical coverage for a Covered Person who is not enrolled in a clinical trial. Routine Patient Costs do not include the investigational item, device, or service itself; items and services that are provided solely to satisfy data collection and analysis needs of the clinical trial and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

J. *Convalescent Care*

Charges made by a Convalescent Nursing Facility for the following services and supplies furnished by the facility during a convalescent confinement. These charges include the following:

1. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis, such as general nursing services. However, admittance fees shall not be included in Room and Board and shall not be covered under the Plan. In the event that the Covered Person chooses a private room when a Semi-Private room is available, the Plan will not cover the additional Room and Board charge.

2. Medical services customarily provided by the Convalescent Nursing Facility. Private duty or special nursing services and Physician's fees are not covered under this benefit, but may be a Covered Expense elsewhere in the Plan.

3. Drugs, biologicals, solutions, dressings, and casts furnished for use during the convalescent confinement.

K. *Diabetes Self-Management Training*

Charges incurred for diabetes self-management training, including information on medical nutrition therapy.

L. *Diagnosis or Treatment of Underlying Cause of Infertility*

Charges for necessary services or fees to diagnose or treat the underlying cause of infertility or sterility. Prescription drugs prescribed for the treatment of infertility are not eligible for Plan coverage.

M. *Durable Medical Equipment*

Charges for the rental of a wheelchair, hospital bed, iron lung, or other Durable Medical Equipment required for temporary therapeutic use, or the purchase of this

equipment if economically justified, whichever is less; charges for maintenance and service necessary for the normal function of Durable Medical Equipment that has been purchased (but not for that which is being rented).

Modifications to houses or vehicles, including, but not limited to, platform lifts, stair lifts, stairway elevators, wheelchair lifts or ramps, and ceiling lifts are not considered Durable Medical Equipment and are not covered under the Plan.

N. *Home Health Care*

Charges for the following home health care services and supplies, including those provided by a Home Health Care Agency:

1. Skilled nursing visits performed by Registered Nurses or Licensed Practical Nurses.

2. Licensed therapists performing Physical Therapy, Occupational Therapy, Speech Therapy, or psychosocial therapy.

3. Certified home health aide visits occurring in conjunction with skilled nursing or licensed therapy visits.

4. Physician calls in the office, home, clinic, or Outpatient department.

5. Medications, services, and medical supplies ordered by a Physician necessary for the treatment of the Covered Person, but not including meals normally prepared in the home.

6. Rental of Durable Medical Equipment and, if approved by the Plan Administrator in advance, purchase of that equipment.

7. Transportation to and from Physician, therapist, Outpatient facility, Hospital, or other provider of treatment, including an ambulance (where the patient's condition mandates that utilization), ambucab (if the diagnosis makes automobile travel unsuitable), licensed taxicab, or mileage for a driver approved by the Plan.

O. *Hospice Charges*

Charges made by a Hospice during a Hospice Benefit Period for the following:

1. Nursing care by a Registered Nurse or a Licensed Practical Nurse, vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse.

2. Licensed therapists performing Physical Therapy, Occupational Therapy, Speech Therapy, or psychosocial therapy.

3. Medical supplies, including drugs and biologicals, and the use of medical appliances.

4. Physician's services.

5. Services, supplies, and treatments deemed Medically Necessary and ordered by a Physician.

6. Room and Board, including any charges made by a Hospice facility as a condition of occupancy.

P. *Hospital Charges*

Charges made by a Hospital for the following:

1. Daily Room and Board and general nursing services or confinement in an Intensive Care Unit, including nursery charges for a Newborn Dependent. In the event that the Covered Person chooses a private room when a Semi-Private room is available, the Plan will not cover the additional Room and Board charge.

2. Necessary services and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, Physical or Occupational Therapy treatments, hemodialysis, and X-ray therapy. Charges incurred for miscellaneous services and supplies by a Newborn Dependent will be covered.

NOTE: The Plan may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to fewer than 48 hours following a normal vaginal delivery, or fewer than 96 hours following a cesarean section. However, pursuant to federal law, the Plan generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or Newborn earlier than 48 hours (or 96 hours, as applicable). In any case, the Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

Q. *Laboratory*

Charges for microscopic tests and laboratory tests.

R. *Loss-Control Services*

Approved fees for loss-control services such as fee negotiations, claim reviews, and fraud and abuse audits.

S. *Medical Supplies*

Charges for dressings, casts, splints, trusses, braces, or other necessary medical supplies, with the exception of orthodontic braces or corrective shoes.

T. *Newborn Care*

Charges for the usual, ordinary, and Routine care of a Newborn.

U. *Nicotine Abuse Treatment*

Charges for Medically Necessary medical care and services rendered in conjunction with treatment for nicotine abuse.

V. *Nurse-Midwives*

Charges for a fully certified or licensed and insured Nurse-Midwife. Delivery must occur within a Hospital or Birthing Center with an OB/GYN Physician present in the facility. The Nurse-Midwife must have a formal written agreement with a Physician who is a specialist in obstetrics and gynecology for OB consultation and referral services.

W. *Obesity Treatment*

Charges for Medically Necessary non-surgical treatment of Obesity, but not charges from diet centers, diet counseling, and exercise programs, including, but not limited to, the cost of food and food supplements (unless stated as covered elsewhere in the Plan document).

Medically Necessary surgical treatment of Obesity is covered only when all of the following requirements are satisfied:

1. The Covered Person has one of the following body mass index (BMI) scores:

   a. ≥ 35 with at least one co-morbidity, such as coronary heart disease, hypertension requiring medication, hyperlipidemia requiring medication, type 2 diabetes mellitus requiring medication, or symptomatic sleep apnea requiring treatment.
   b. ≥ 40 with or without co-morbidities.

2. The surgeon is a member of the American Society for Metabolic and Bariatric Surgery.

3. The Covered Person is ≥ 18 years of age.

4. The Covered Person has received medically supervised and documented conventional and less intrusive weight-management treatments, which may include, but are not limited to, diet/lifestyle changes (including a

dietician consultation), exercise, and prescription drug therapy(ies). Documentation must objectively prove the Covered Person actively participated in and complied with the treatment for at least six consecutive months and within 24 months before the proposed surgery date, with monthly office visits, without a net gain in weight.

5. The Covered Person has received a documented psychological evaluation before surgery to determine the psychological component of the individual's Obesity (specifically any underlying psychological conditions that, if treated, could lead to the individual's successful weight loss with conservative approaches) and whether the individual is mentally and emotionally capable of living with the new diet restrictions following the surgery. The provider must certify in writing that he or she is not the surgeon who will perform the surgery and is not affiliated in any way with that surgeon or the facility where the surgery will take place (if a freestanding facility).

6. Documentation supports that additional conventional and less intrusive treatment is not expected to decrease the Covered Person's weight to a point where the Medically Necessary surgical treatment of Obesity is no longer applicable.

The Plan will cover treatment or complications that arise during or subsequent to a surgical procedure to treat Obesity and will pay the charges in the same manner as any other Illness.

However, in the event a Covered Person began Obesity treatment before the effective date of this Plan document and such treatment continues after this date, these charges will be administered in accordance with the Plan provisions that were in effect when this Obesity treatment first commenced.

X. *Obstetrics*

Physician's charges for obstetrical services are paid on the same basis as for an Illness, including charges for the initial examination of a Newborn by a Physician, and the mother's prenatal care. Benefits are provided for a Pregnancy of a Dependent child.

Y. *Oral Surgery Performed at a Hospital on an Outpatient or Inpatient Basis; Illness- and Accident-Related Dental Treatment*

Charges incurred for the following:

1. An alveolectomy, a gingivectomy, or a vestibuloplasty, for the removal of impacted or partially impacted teeth (no allowance for other extractions), or diagnostic x-rays performed in connection with an oral surgery. These procedures will only be considered eligible by the Plan if performed at a Hospital on an Outpatient basis, or, if deemed to be Medically Necessary by the attending Physician, on an Inpatient basis. Additionally, the

Covered Person must have a medical condition that requires these procedures to be performed on an Outpatient or Inpatient basis at a Hospital. For purposes of this provision, a medical condition may include, but is not limited to, the following: bleeding or clotting abnormalities; unstable angina; severe respiratory disease; and a known reaction to analgesics, anesthetics, etc.

2. Treatment required because of an Illness or Accidental bodily Injury to natural teeth. A Covered Person's dental plan/policy, if any, shall be considered the primary plan and this Plan shall be the secondary plan for purposes of paying expenses deemed eligible under this provision. Expenses related to an Accident must be incurred within six months of the date of the Accident. Dental services that are typically preventive in nature, such as oral examinations, cleanings, and X-rays, are not eligible under this benefit unless Medically Necessary for the treatment of the Injury or Illness.

Z. *Orthoptics/Vision Therapy*

Charges for Medically Necessary Orthoptics or Vision Therapy when diagnosed and/or administered by a provider who is duly licensed by the state to perform such services.

AA. *Orthotic or Prosthetic Appliances*

Charges for Orthotic or Prosthetic Appliances or artificial limbs, eyes, or larynges, but not the replacement of these unless the current Orthotic or Prosthetic Appliance or artificial limb, eye, or larynx is not functional.

BB. *Oxygen and Other Gases*

Charges for oxygen and other gases and their administration.

CC. *Physician Services*

The services of a Physician for medical care including office visits, Telemedicine e-visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, surgical procedures to diagnose and treat Injuries and Illnesses, and surgical opinion consultations, unless specifically stated as a Covered Expense elsewhere in the Plan.

DD. *Private Duty Nursing*

Charges for private duty nursing services provided by a Home Health Care Agency in a private home (non-facility) setting will be deemed Medically Necessary and covered for a patient if the care satisfies the Plan's Medically Necessary criteria as well as all of the following requirements:

1. The services are not permanent but temporary (short-term) and transitional in nature and may include training caregivers to provide the necessary services.

2. The services are for the purpose of restoring/maintaining the Covered Person's maximal level of function and health.

3. Services require a longer duration of skilled care than can be provided by a skilled nursing visit as described in the Home Health Care benefit.

4. The nursing care is required so frequently that the need for care is continuous whether delivered by a skilled professional or a trained caregiver.

5. The skilled care is provided by a nurse who is not related to or living with the patient. Skilled nursing services are those services that must be performed by a registered nurse or licensed practical nurse or require a nurse to train caregivers to perform.

6. The Covered Person is medically stable (for example, the Covered Person is clinically stable for discharge from the Hospital to the home) and all reasonably anticipated medical needs can be met in the home with temporary (short-term) private duty nursing support.

7. There is at least one identified caregiver for the Covered Person who will be trained to provide care to the Covered Person when the nurse is not on duty and after the temporary (short-term) private duty nursing care ends. If no family or caregivers are available to provide this care, any private duty nursing services provided will not be eligible for payment under this benefit. Where the Covered Person is not eligible for private duty nursing care under this benefit, alternative level of care placement, such as a skilled nursing facility or custodial nursing home, may be appropriate.

8. The Utilization Review Department must certify the care and have proof of an established transitional treatment plan on file before private duty nursing services commence. As part of this certification process, the Plan may require (initially and periodically) a physician certification letter from the Covered Person's Physician with the following components:

    - Diagnosis
    - Treatment plan
    - Specific duties
    - Explanation of medical necessity
    - Estimated length of time care is needed
    - Hour-by-hour nursing notes must be attached to the letter (if determined to be necessary and requested by the Claim Administrator or the Utilization Review Department)

    Private duty nursing care cannot be reviewed or processed for payment without an initial and periodic certification that the care is Medically Necessary.

Generally, 24-hour per day private duty nursing care will not be approved. The hours and duration of the initial approval for private duty nursing care will be determined by the Utilization Review Department. Approval for continued private duty nursing care for the period determined by the Plan shall be contingent upon:

- Updated medical orders from the prescribing Physician
- Continued eligibility by meeting all of the initial criteria

Charges for the following are not covered under this benefit:

1. Maintenance care or custodial care for a Covered Person. In no event will such care be considered eligible under the Private Duty Nursing benefit.

2. Respite care for a caregiver.

3. Services to allow the Covered Person's family or caregiver to work or to leave the home for any other reason.

4. Private duty nursing services rendered in a facility setting, including, but not limited to, care provided to a patient in an acute Inpatient Hospital, Inpatient rehabilitation facility, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility.

5. Services provided in a school setting.

6. Services for senile deterioration or mental deficiency.

EE. *Radiation Therapy and Chemotherapy*

Charges for radiation therapy and treatment and for chemotherapy and treatment.

FF. *Rehabilitative Therapies*

Charges incurred for the following:

1. Treatment or services rendered by a licensed physical therapist or a licensed occupational therapist for Physical or Occupational Therapy in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

2. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative Speech Therapy for speech loss or impairment caused by an Illness or Injury (other than a Functional Nervous Disorder), or caused by surgery performed because of an Illness or Injury. If the speech loss or impairment is caused by a congenital anomaly, surgery to correct the anomaly must have been performed before the therapy.

GG. *Routine Preventive Care*

Charges for Routine preventive care for Covered Persons, including, but not limited to, examinations and items and services listed in the following four categories are eligible under this benefit, as described in the Schedule of Benefits:

1. Items and services rated "A" or "B" by the U.S. Preventive Services Task Force, including screenings for high blood pressure, cervical cancer, cholesterol abnormalities, colorectal cancer, depression, diabetes, hearing loss, hemoglobinopathies (Sickle Cell Disease), hepatitis B, HIV, and osteoporosis; screenings and counseling to reduce alcohol misuse; screenings and counseling for Obesity treatment; counseling for a healthy diet; and counseling for tobacco use.

2. Immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for children and adults.

3. Preventive care and screenings for children as recommended by the Health Resources and Services Administration.

4. Preventive care and screenings for women as recommended by the Health Resources and Services Administration.

A list of covered preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card (alternatively, see the Other Basic Information About the Plan section).

IMPORTANT: The following exceptions to the online list of covered preventive care items and services apply to this Plan:

- The Plan will cover either one Routine colonoscopy or one diagnostic colonoscopy per Covered Person per Plan Year under this benefit. As specified in the Schedule of Benefits, charges for any additional colonoscopy procedures in a Plan Year may be considered for payment under another Plan benefit.

- The Plan will cover only one Routine mammogram per Covered Person per Plan Year under this benefit. As specified in the Schedule of Benefits, charges for any additional mammogram procedures in a Plan Year may be considered for payment under another Plan benefit.

- Well-baby and Routine child care visits will be subject to the following age-related frequency limitations: (1) for Dependent children from birth to 12 months old, up to six visits will be covered under this benefit; (2) for Dependent children from 13 months old to 23 months old, up to six visits will be covered under this benefit; (3) for Dependent children from 24 months old

to 35 months old, up to six visits will be covered under this benefit; (4) for Dependent children from 36 months old to 47 months old, up to two visits will be covered under this benefit; and (5) for Dependent children 47 months or older, one visit will be covered per Plan Year under this benefit. Charges for visits that exceed these limitations are not covered by any other benefit in this Plan.

- Any Out-of-Network charges for breast pumps will be subject to the maximum listed in the Schedule of Benefits.

- Charges for the rental or purchase of hospital-grade breast pumps will not be considered covered charges under this benefit.

- The Plan will cover certain Routine immunizations administered by a Public Health Department under this benefit.

HH. *Temporomandibular Joint Dysfunction Services*

Charges for the diagnosis and treatment of temporomandibular joint dysfunction that are deemed to be eligible are payable the same as any other Illness; that is, cost-sharing provisions such as Deductibles, Coinsurance, or co-payments may apply depending upon the type of service rendered. The Plan will only allow charges for surgery if all other means of generally accepted treatment have been exhausted.

Charges for orthodontic braces are not covered under this benefit.

II. *Transgender Services*

Charges for Medically Necessary care, services, or treatment provided in connection with a gender dysphoria (also known as gender identity disorder) diagnosis or another transgender-related medical diagnosis, including, but not limited to, gender transition/reassignment surgery and related services, continuous hormone replacement therapy (i.e., hormones of the desired gender) and lab test services related to this hormone therapy, and psychotherapy. Transgender-related services will only be covered to the extent that the Plan would otherwise provide such benefits when the same service is not related to gender dysphoria or a transgender-related diagnosis. Furthermore, the Plan's coverage of transgender services will be subject to all the usual terms and conditions of the Plan, such as utilization review requirements and any applicable exclusions. Examples of transgender-related Cosmetic Procedures or procedures that would not satisfy the Plan's Medically Necessary criteria include, but are not limited to, the following: (1) pubertal suppression therapy; (2) voice therapy or voice modification surgery; (3) medications administered for hair loss or growth or for cosmetic purposes only; (4) facial bone reconstruction or face lift, including rhinoplasty; (5) blepharoplasty; (6) lip reduction/enhancement; (7) hair removal/hairplasty; (8) liposuction or lipofilling; (9) breast augmentation or implants; and (10) reductive thyroid chondroplasty (trachea shave).

JJ. *Transplants*

Services and supplies in connection with organ and/or tissue transplant procedures, subject to the following conditions:

1. The Claim Administrator may require additional information from Physicians to determine if benefits are excluded owing to the experimental or investigational nature of some transplant procedures or are otherwise excluded under the Plan. The Claim Administrator may require the Covered Person to obtain a second opinion on whether the transplant procedure is Medically Necessary. A second opinion will be in accordance with the Second Surgical Opinion Benefit, if any.

2. If the donor is a Covered Person under this Plan but the recipient is not, the donor's Covered Expenses will be considered under this benefit on a secondary basis to the recipient's plan.

3. If the recipient is a Covered Person under this Plan, the recipient's Covered Expenses are covered under this benefit.

4. If the donor is not a Covered Person under this Plan but the recipient is, the donor's expenses will be covered under this benefit on a secondary basis to the donor's plan if the expenses are Covered Expenses (had the expenses been incurred by a Covered Person).

   Benefits paid to or on behalf of the donor by this paragraph are treated as though they were paid to the recipient for purposes of any Deductibles, payment percentages, Plan maximums, etc.

5. Covered Expenses include the cost of securing an organ from a cadaver or tissue bank, the surgeon's charge for removal of the organ, a Hospital's charge for storage or transportation of the organ, and charges for travel (including lodging and transportation) that qualify under Section 213 of the Code and have been authorized by the Claim Administrator.

KK. *Voluntary Sterilizations*

Charges for voluntary sterilization of Participants and Dependents.

LL. *X-rays*

Charges for X-rays.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

NOTE: Some of the following exclusions may conflict to some extent with the preventive care services required by Health Care Reform to be covered under this Plan as a Routine Preventive

Care expense. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card or by calling the Claim Administrator at the telephone number printed on the back of the Covered Person's identification card. In the event an exclusion below conflicts with the provisions of the summary, the provisions of the summary will rule.

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan. No benefits shall be payable by the Plan for the following items:

A. *Acupuncture; Acupressure*

Charges for acupuncture or acupressure.

B. *Charges Not Medically Necessary, Above Usual and Customary, or Not Physician Recommended or Approved*

Unless specifically shown as a Covered Expense elsewhere in the Plan, charges that meet any of the following criteria:

1. Are incurred in connection with services and supplies that are not Medically Necessary for treatment of an Injury or Illness.

2. Are in excess of Usual and Customary charges.

3. Are not in compliance with generally accepted billing practices for unbundling or multiple procedures.

4. Are not recommended and approved by a Physician.

C. *Completion of Claim Forms*

Charges incurred for completion of insurance or benefit payment claim forms.

D. *Correctional Institutions*

Charges incurred while the Covered Person is confined in a penal or correctional institution.

E. *Cosmetic Procedures*

Charges incurred in connection with the care, treatment, or surgery performed for a Cosmetic Procedure. This exclusion shall not apply to procedures necessary to lessen or correct a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an Accident or trauma, or a disfiguring disease for a Covered Person. The Plan does not cover replacement of breast implants that were initially considered to be for cosmetic purposes and were not Medically Necessary.

F. *Dental*

Charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue, or a molar process, and any other dental, orthodontic, or oral surgical charges, unless expressly included in a benefit of this Plan.

G. *Effective Date of Coverage*

Charges incurred before a Covered Person's effective date of coverage under the Plan, or after coverage and any extensions of participation are terminated.

H. *Experimental; Investigational*

Charges for services or supplies that are Experimental or Investigational in nature.

I. *Fees and Taxes*

Charges for sales tax, processing fees, fees for the attainment of medical records, and the like.

J. *Free School-Provided Special Education Services*

Charges for services provided for physically and/or mentally impaired individuals where a school is required to provide those services free of charge (e.g., special education).

K. *Infertility*

Unless expressly included in a benefit of this Plan, charges related to or in connection with all infertility or sterility testing or treatment, medications prescribed for the treatment of infertility, procedures to restore or enhance fertility, or any artificial means to achieve Pregnancy or ovulation, including, but not limited to, the following: (1) artificial insemination; (2) in-vitro fertilization; (3) induced ovarian hyperstimulation; (4) gamete intrafallopian transfer (GIFT); (5) zygote intrafallopian transfer (ZIFT); (6) tubal ovum transfer; (7) embryonic freezing, transfer, or implantation procedures; or (8) sperm banking. Charges incurred in connection with gender transition for fertility preservation procedures involving, but not limited to, cryopreservation; storage and thawing of reproductive tissue; or procurement and storage of embryos, sperm, or oocytes are excluded under this Plan.

L. *Inorganic Sexual Dysfunction Treatment*

Charges for treatment of inorganic sexual dysfunction or inadequacy such as implants, but not including any charges rendered in connection with eligible gender transition treatment. Charges for individual psychotherapy, group therapy, psychological testing by a Psychologist, and electroshock therapy for the treatment of a Mental Illness or Disorder are also not subject to this exclusion and will be considered as Covered Expenses under the Behavioral Care Benefit, if any.

M. *Legal Obligation to Pay Charges*

Charges incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

N. *Missed Appointments*

Charges for failure to keep an appointment.

O. *Non-Accepted Treatment and Procedures Not Medically Necessary*

Charges for services, supplies, or treatments that the medical community does not recognize as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury, or charges for procedures, surgical or otherwise, that the medical community specifically lists as having no medical value. This exclusion does not apply to Routine preventive care expressly covered by the Plan.

P. *Non-Human Treatment*

Charges for non-human organ transplants, cloning, or xenografts. However, this exclusion will not apply if the procedure is Medically Necessary, is not Experimental or Investigational, and is commonly and customarily recognized throughout the Physician's profession as appropriate in treating the diagnosed Illness or Injury.

Q. *Non-Medical Services, Supplies, Etc.*

Charges incurred for services or supplies that constitute personal comfort or beautification items; television or telephone use; or Custodial Care, education or training, or expenses actually incurred by other persons.

R. *Non-Professional Nursing Services*

Charges for professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless that care was vital as a safeguard of the Covered Person's life, or unless that care is specifically listed as a Covered Expense elsewhere in the Plan.

S. *Over-the-Counter Products*

Charges for all over-the-counter products, even though prescribed by a Physician, Physician's Assistant, or Nurse Practitioner, unless specifically stated as a Covered Expense elsewhere in the Plan.

T. *Physician Not Present*

Charges for Physicians' fees for any treatment that is not rendered by or in the physical presence of a Physician, except as provided elsewhere in the Plan (e.g., Physician's Assistant, Nurse Practitioner, or eligible Telemedicine services).

U. *Prescription Drugs*

Charges for all prescription drugs that may be purchased through a retail pharmacy or a mail-order prescription drug service. However, if prescribed in writing by a Physician, a Physician's Assistant, or a Nurse Practitioner within the legally appointed scope of his or her license, eligible drugs that are administered in an Inpatient or Outpatient health care facility will be covered when determined to be either (1) Medically Necessary for the treatment of an Illness or Injury or (2) eligible Routine preventive care medications.

V. *Provider Related to Covered Person*

Charges for services rendered by a Physician, nurse, licensed therapist, or Home Health Care Agency employee to a Covered Person if the individual rendering services is the Covered Person or a Close Relative of the Covered Person or resides in the same household as the Covered Person.

W. *Rest Care or Treatment Not Connected With Injury or Illness*

Charges for hospitalization when the confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or hospitalization for any Routine physical examinations or tests not connected with the actual Illness or Injury.

X. *Reversal of Sterilization or Reversal of Gender Transition/Reassignment Surgery*

Charges resulting from, or in connection with, the reversal of a sterilization procedure or reversal of a transgender surgical procedure (also known as sex transformation surgery, sex/gender reassignment surgery, or genital surgery).

Y. *Surrogate Pregnancy*

Charges incurred for actual or attempted impregnation or fertilization by any means involving a surrogate donor or surrogate recipient.

Z. *Travel to Foreign Countries for Specific Treatment*

Charges incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs, or supplies. This exclusion does not apply if the location was closer to, or substantially more accessible from, the Covered Person's temporary or permanent residence (or if an emergency exists, the place where the Covered Person suffered the Illness or Injury) than the nearest location within the United States that was

adequately equipped to deal with, and was available for the treatment of, the Covered Person's Illness or Injury.

AA. *Vision; Hearing*

Charges incurred in connection with eye refractions or the purchase or fitting of eyeglasses, contact lenses, or hearing aids. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage is in effect. This exclusion does not apply to benefits expressly provided by a Vision Benefit or Hearing Benefit, if any. Charges incurred for or relating to radial keratotomy or keratectomy or similar procedures are excluded under this Plan.

BB. *War or Armed Forces Service*

Charges caused as a result of war or any act of war, whether declared or undeclared, if incurred during service (including part-time service and national guard service) in the armed forces of any country.

CC. *Weekend Hospital Admittance*

Charges for Room and Board incurred in connection with a Hospital admittance on Friday, Saturday, or Sunday, unless significant medical treatment is given on those days. Significant medical treatment includes any treatment not normally connected with Room and Board or general nursing services.

DD. *Work-Related*

Charges for the treatment of an Injury or Illness that arose out of or in the course of any employment or occupation for wage or profit for which the Covered Person is or will be receiving benefits under any workers' compensation or occupational disease law or any similar law. Typically, work-related medical claims will be paid by the Employer's Workers' Compensation insurance policy. However, the Plan may make a provisional payment in advance of the determination of whether or not the claim is eligible for workers' compensation benefits, but the Plan will have the right to recover any amounts paid if workers' compensation benefits are subsequently paid for these work-related claims.

NOTE: **These exclusions will not apply to the extent they would violate the Americans With Disabilities Act or any other applicable law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.**

SCHEDULE FOR ELIGIBILITY AND PARTICIPATION

ACTIVE COVERAGE ELIGIBILITY REQUIREMENTS

In order to be eligible to participate in this Plan, an individual must satisfy the following requirements:

A. Be currently employed by the Employer and satisfy the following requirements:

1. Can be identified in one of the following employment classifications:

a. Working in Full-Time Employment for 40 or more hours per week.

b. Working in a Part-Time Eligible Position (as this term is further defined in the Employer's policies).

2. Have been employed in Full-Time Employment or a Part-Time Eligible Position by the Employer in accordance with the following New Hire Health Plan Eligibility Schedule. Under no circumstances will an individual be allowed to participate in the Plan until he or she is working in Full-Time Employment or classified by the Employer to be working in a Part-Time Eligible Position.

New Hire Health Plan Eligibility Schedule:

Date of Hire	**Eligible Date**
January 1 through January 31	March 1
February 1 through February 28/29	April 1
March 1 through March 31	May 1
April 1 through April 30	June 1
May 1 through May 31	July 1
June 1 through June 30	August 1
July 1 through July 31	September 1
August 1 through August 31	October 1
September 1 through September 30	November 1
October 1 through October 31	December 1
November 1 through November 30	January 1
December 1 through December 31	February 1

B. Be a Dependent of an Employee who is eligible for and enrolled in the Employer's Medicare Supplemental coverage because of End Stage Renal Disease (ESRD). These individuals may be subject to special rules for eligibility, enrollment, and contributions as described in the Employer's written policies. In the event of a conflict between this document's provisions and the Employer's written policies permitting this coverage, the Employer's policies will rule.

NOTES:

1. An individual who is eligible to participate in the Plan as both a Participant and a Dependent may enroll for coverage under the Plan as both a Participant and as a Dependent. However, any claims submitted by such individuals would be subject to the Plan's usual Coordination of Benefits provision.

2. As permitted under Health Care Reform and detailed in the Employer's written policies, the Employer will use the Look-Back/Stability Period Safe Harbor method to determine the eligibility of an Employee who does not work in Full-Time Employment or a Part-Time Eligible Position to participate in the Plan. Contact the Employer for more information.

RETIREE COVERAGE ELIGIBILITY REQUIREMENTS

In order to be eligible to participate in this Plan, an individual must satisfy one of the following requirements:

A. Be classified by the Employer as a Retiree and be eligible for Retiree coverage under the Plan as detailed in the Employer's written policies.

B. Be a surviving Dependent of a deceased Retiree and be eligible for Retiree coverage under the Plan as detailed in the Employer's written policies.

C. Be a Dependent of a Retiree who is eligible for and enrolled in the Employer's Medicare Supplemental coverage. These individuals may be subject to special rules for eligibility, enrollment, and contributions as described in the Employer's written policies. In the event of a conflict between this document's provisions and the Employer's written policies permitting this coverage, the Employer's policies will rule.

NOTE: Individuals who are covered under the terms of this section and the Retiree Coverage section on page 48 will generally no longer be eligible for coverage under the Plan upon becoming enrolled in the Employer's Medicare Supplemental coverage. See the Retiree Coverage section for more details.

PARTICIPANT EFFECTIVE DATE

Participation in the Plan will start for new Employee applicants on the date on which they meet the Active Coverage Eligibility Requirements stated above. Participation in the Plan will start for new Retiree applicants on the first of the month following the date on which they meet the Retiree Coverage Eligibility Requirements stated above. Both Employee and Retiree applicants must also meet the requirements described in the Participant Enrollment section below.

EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION

NOTE: The Long-Term Disability Leave Extension of Participation (except to the extent that it is also a Family and Medical Leave Act of 1993 [FMLA] extension of participation) will be offset against the length of a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, extension of participation. Any other Employer-provided extension of

participation, including the Short-Term Disability Leave Extension of Participation, will be in addition to the length of a COBRA extension of participation.

*Short-Term Disability Leave Extension of Participation ..... Up to 180 days**

*Long-Term Disability Leave Extension of Participation .....Through the end of the month in which the first 180 days of the Long-Term Disability is exhausted**

*If a Participant exhausts the Short-Term Disability Leave Extension of Participation, he or she may be eligible for continued coverage under the Long-Term Disability Leave Extension of Participation provided the approved disability leave continues.

Approved Leave of Absence Without Pay Extension of Participation.....For the duration of the approved leave, provided the Employee makes any required monthly Plan payments

Military Leave Extension of Dependent Participation .....Dependents of an Employee on a military leave will be covered for the duration of the Employee's military leave pursuant to Board of Commissioners' Resolution #08270

Parental Leave Extension of Participation..... Up to six weeks (240 hours)

Additional information regarding Extensions of Participation is provided on page 50.

***ANNUAL OPEN ENROLLMENT PERIOD**.....Employees: September and October*; Retirees: February 1 through January 31*

*Generally, the above-stated Annual Open Enrollment Period will apply to all Employees. However, other open enrollment periods may occur periodically as required by collective bargaining agreements.

Additional information regarding the Annual Open Enrollment Period is provided on page 46.

***REINSTATEMENT**..... As required as a result of a Personnel Appeal Board Decision, Arbitrator's Award, or Judicial Directive*

***RETIREE COVERAGE** .....Yes*

Additional information regarding Retiree coverage is provided on page 48.

PARTICIPANT ELIGIBILITY

A person is eligible for Participant Coverage under the Plan if the person meets all of the Participant eligibility requirements listed in the Schedule for Eligibility and Participation.

PARTICIPANT ENROLLMENT

Participant Coverage begins on the first of the month following the date on which the person meets both of the following requirements:

A. The person is eligible for Participant Coverage.

B. The person has made written application for Participant Coverage on a form acceptable to the Plan Administrator on or before the first date on which coverage could begin. For more details on the Plan's eligibility waiting period for new hires, refer to the Active Coverage Eligibility Requirements section for the New Hire Health Plan Eligibility Schedule.

If application for Participant Coverage is not made by the date coverage could begin, the Employer will automatically enroll the Participant in an assigned benefit program. Unless the Employee formally notifies the Employer that he or she is declining coverage by the coverage start date, the Participant may not waive the assigned benefit program. Enrollment in the assigned benefit program shall remain in effect until the last day of the Plan Year unless the Participant experiences special enrollment rights.

If the applicant declines coverage on or before the first date on which coverage could begin, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

A. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

   1. The other coverage was COBRA, and it has been exhausted.

   2. The applicant became ineligible (i.e., as a result of a Change in Status).

   3. Employer contributions for the coverage have been terminated.

   4. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

   5. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

   6. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).

7. A plan's lifetime limit on all benefits was applied.

Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

B. The applicant has acquired a new Dependent by marriage, birth, adoption, or placement for adoption. In this situation, special enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, or placement for adoption.

C. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

D. The applicant experiences a change (other than those described above) that would permit a mid-year election change in accordance with the rules established by Section 125 of the Code.

An applicant with special enrollment rights must make application for Participant Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage; marriage, birth, adoption, or placement for adoption (whichever is applicable); or the Section 125-permitted election change event. However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Participant Coverage shall be effective as of the date of the loss of other coverage, the marriage, birth, adoption or placement for adoption, the loss of Medicaid or CHIP eligibility, the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, or the Section 125-permitted election change event.

An applicant with special enrollment rights who fails to make application for Participant Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

All Participant Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

DEPENDENT ELIGIBILITY

A person is eligible for Dependent Coverage under the Plan when both of the following requirements are met:

A. The person is a Dependent.

B. The Participant on whom the person is dependent is eligible for Participant Coverage. However, this requirement shall not apply to a surviving Dependent of a deceased Retiree or a Dependent of an Employee or Retiree who is enrolled in the Employer's Medicare Supplemental coverage.

DEPENDENT ENROLLMENT

Except for a surviving Dependent of a deceased Retiree or a Dependent of an Employee or Retiree who is enrolled in the Employer's Medicare Supplemental coverage (these individuals will instead be subject to the enrollment requirements specified in the Employer's written policies), Dependent Coverage begins when all of the following requirements are met:

A. The person is eligible for Dependent Coverage.

B. The Participant on whom the person is dependent is a Covered Person.

C. The Participant makes a written application for Dependent Coverage on a form acceptable to the Plan Administrator on or before the first date that coverage could begin. This requirement does not apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption, during the placement of the Dependent for adoption, or legal guardianship). For these Dependents, see the next paragraph below.

Notwithstanding the immediately preceding paragraph, the following special rules apply to newly acquired Dependents by marriage, birth, or court order or decree (e.g., adoption or during the placement of the Dependent for adoption):

1. A Participant's spouse may be enrolled as a Dependent as of the date of marriage if written application for Dependent Coverage for the spouse is made within 30 days of the date of marriage.

2. A Participant's Newborn will be covered from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. The provision shall not apply to, nor in any way affect, the maternity provisions of this Plan, if any, applicable to the mother.

3. If a Dependent is acquired other than at the time of the Dependent's birth on account of marriage, or a court order or decree, that Dependent may be enrolled as a Dependent as of the date of the marriage, court order or decree, if written application for Dependent Coverage for the new Dependent is made within 30 days of the court order, decree, or marriage.

Dependent Coverage for a child to be placed with a Participant through adoption is effective as of the date the child is placed for adoption, if written application for Dependent Coverage for the child is made within 30 days of the child's placement. A child is considered placed for adoption if the Participant has a legal obligation for total or partial support of the child in anticipation of the child's adoption.

If application for Dependent Coverage is not made within 30 days after the date coverage could have begun, the applicant must wait until the Annual Open Enrollment Period unless the applicant has special enrollment rights to enroll during a Special Enrollment Period. An applicant has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

1. The applicant declined coverage when initially eligible or during a subsequent Annual Open Enrollment Period because the applicant had coverage under another group health plan or health insurance coverage, and that other coverage was subsequently lost for one of the following reasons:

    a. The other coverage was COBRA, and it has been exhausted.

    b. The applicant became ineligible (i.e., as a result of a Change in Status).

    c. Employer contributions for the coverage have been terminated.

    d. The other coverage was an HMO, and the individual no longer lives or works in the service area of the HMO (whether or not by choice of the individual).

    e. The other coverage no longer offers any benefits to a class of similarly situated individuals (e.g., part-time employees).

    f. A benefit package option is terminated (unless the individual is provided a current right to enroll in alternative health coverage).

    g. A plan's lifetime limit on all benefits was applied.

    Proof that the other coverage was lost must be provided to the Plan Administrator upon request.

    An individual who lost other coverage on account of nonpayment of the required contribution or for cause (e.g., filing fraudulent claims) shall not have special enrollment rights to enroll during a Special Enrollment Period. An individual who voluntarily terminates other coverage shall not be considered to have special enrollment rights.

2. The applicant has acquired a new Dependent by marriage, birth, adoption, placement for adoption, or legal guardianship. In this situation, special

enrollment rights are available to the Employee, the Employee's spouse, and any child who became a Dependent on account of the marriage, birth, adoption, placement for adoption, or legal guardianship.

3. The applicant's coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is terminated as a result of the applicant's loss of eligibility for Medicaid or the CHIP, or the applicant becomes eligible for a premium assistance subsidy under Medicaid or a CHIP to obtain coverage under this Plan.

4. The applicant experiences a change (other than those described above) that would permit a mid-year election change in accordance with the rules established by Section 125 of the Code.

An applicant with special enrollment rights must make application for Dependent Coverage during the Special Enrollment Period, which is generally during the first 30 days after the loss of other coverage; marriage, birth, adoption, placement for adoption (whichever is applicable); the Section 125-permitted election change event; or legal guardianship. However, if the loss of other coverage was caused by the application of the plan's lifetime limit on all benefits, the Special Enrollment Period will occur during the 30-day period immediately following the first date on which a claim was denied for that reason. Further, in the case of the loss of Medicaid or CHIP eligibility or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy, the Special Enrollment Period is during the first 60 days after the loss or gain of eligibility. Dependent Coverage shall be effective as of the date of the loss of other coverage; the marriage, birth, adoption or placement for adoption; the loss of Medicaid or CHIP eligibility; or the gain of eligibility for a Medicaid or CHIP premium assistance subsidy); the Section 125-permitted election change event; or legal guardianship.

An applicant with special enrollment rights who fails to make application for Dependent Coverage during the Special Enrollment Period must wait until the next Annual Open Enrollment Period or until special enrollment rights again apply, whichever occurs first.

The requirement to make written application for a Newborn Dependent is waived.

Except for Newborn coverage, which shall begin at the moment of birth, Dependent Coverage under the Plan shall begin at 12:01 a.m. local time on the date on which coverage is to begin.

SWITCHING COVERAGE STATUS

If a Dependent is eligible to be enrolled as a Participant, enrollment may be effective on the date of the enrollment. If a Participant is eligible to be enrolled as a Dependent, enrollment may be effective on the date of the enrollment. Any switches in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage.

PARTICIPANT CONTRIBUTION

The Employer may require a contribution from Participants (or a Dependent if covered separately from a Participant in accordance with the Plan's provisions permitting such coverage) in order to maintain Employee participation and/or the participation of any Dependents in the Plan. If Participant contributions are required, the Employer will notify the Participants of the designated amount. If the Employer maintains a Section 125 Plan, the required contributions may be paid on a pre-tax basis under that plan.

ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in September and October each year for eligible individuals and their dependents to make coverage elections under this Plan for the following Plan Year. Eligible individuals (e.g., Employees working in Full-Time Employment and Part-Time Eligible Position who have satisfied the initial participation eligibility requirements and who continue to be eligible) may make elections during the Annual Open Enrollment Period and those coverage elections will go into effect on January 1 following the Annual Open Enrollment Period.

The Plan will also offer a 12-month Annual Open Enrollment Period from February 1 to January 31 each year for eligible Retirees and their dependents to elect coverage under this Plan as a Retiree for the following Plan Year. For those Retirees and their dependents who are eligible to enroll during the Annual Open Enrollment Period, their effective date of coverage would be January 1 following the Annual Open Enrollment Period election, except in the case of any elections made in January. In the event a Retiree elects coverage under the Plan during the month of January, the effective date of coverage for that Retiree and their eligible dependents would be the January 1 coincident with or immediately prior to the election.

Other open enrollment periods may occur periodically as required by collective bargaining agreements.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation or Retiree Coverage provisions:

A. Through the end of the month in which the Participant's employment terminated.

B. Through the end of the month in which the Participant goes on a leave of absence.

C. Through the end of the month in which the Participant ceases to be in a classification (e.g., Full-Time Employment or Part-Time Eligible Position) shown in the Schedule for Eligibility and Participation.

D. The last day of the period for which the Participant fails to timely make any required contribution for coverage.

E. Date on which the Plan is terminated; or with respect to any benefit(s) of the Plan, the date of termination of such benefit(s).

F. Through the end of the month in which the Plan Administrator terminates the Participant's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits.

G. Through the end of the month in which the Participant provides notice of voluntary withdrawal. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, such contributions will continue to be assessed through the end of that plan's plan year unless the voluntary withdrawal occurs during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

H. Date of the Participant's death. However, the Plan will continue to cover any surviving Dependents through the end of the month in which the death occurs (see Dependent Termination section below).

Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

REINSTATEMENT

Reinstatement is not available under this Plan, except as required by law, as required by a Personnel Appeal Board Decision, or pursuant to a judicial or quasi-judicial proceeding (see page 40). Accordingly, a veteran's right and entitlement to reinstatement on returning from military training or service shall be governed by the Uniformed Services Employment and Reemployment Rights Act (USERRA), and any other applicable laws or regulations. Further, see the Family and Medical Leave Act of 1993 (FMLA) section below regarding the right to reinstatement upon return to work from an FMLA leave. The Plan will also allow reinstatement in accordance with the break-in-service provisions set forth in Health Care Reform's employer shared responsibility provisions. Otherwise, a Participant whose coverage terminates and who resumes working in Full-Time Employment or a Part-Time Eligible Position with the Employer will be considered a new Employee for purposes of determining when coverage begins.

DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates, except as provided in the Extension of Participation or Retiree Coverage provisions:

A. Except in the case of a Dependent child reaching the maximum age of eligibility (as further discussed in provision B. below), through the end of the month if the Dependent ceases to be a Dependent as defined in the Definitions section. However, in no event will a Participant's ex-spouse or step-child remain covered

after the date of the Participant's divorce or legal separation (i.e., coverage for these individuals will always end on the date the divorce or legal separation occurs).

B. Through the end of the Calendar Year in which a Dependent child turns 26 years of age.

C. Except as otherwise provided for in provision J. below, date of termination of the Participant's coverage under the Plan. A Participant's coverage will generally be maintained through the end of the month in most termination situations (see Participant Termination section above for more details).

D. The last day of the period for which the Participant fails to make any required contributions for Dependent Coverage in a timely manner.

E. Through the end of the month in which the Plan Administrator terminates the Dependent's coverage for cause, which includes a termination for fraud or misrepresentation (whether intentional or unintentional) in an application for enrollment or a claim for benefits. However, coverage generally cannot be retroactively rescinded absent fraud or intentional misrepresentation.

F. Date on which the Plan or a benefit of the Plan is terminated.

G. Through the end of the month in which notice of voluntary withdrawal is made by or on behalf of the Dependent. However, where required contributions for coverage are paid on a pre-tax basis through the Employer's Section 125 plan, such contributions will continue to be assessed through the end of that plan's plan year unless the voluntary withdrawal occurs during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Employer's Section 125 plan.

H. Through the end of the month in which the Employee or Retiree on whom the person is dependent terminates coverage under the Employer's Medicare Supplemental coverage.

I. Date of the Dependent's death.

J. Through the end of the month in which the Participant's death occurs.

The Participant is obligated to immediately report to the Plan Administrator any change that would result in a Dependent's termination of coverage. Expenses incurred after the date of termination are not covered by the Plan unless an extension of participation applies (see Extensions of Participation section below).

RETIREE COVERAGE

The Plan will allow any eligible Participant who satisfies the requirements specified in the Retiree Coverage Eligibility Requirements section and meets the definition of a Retiree to elect

group health coverage for him/herself and any eligible dependent(s). Further, any surviving Dependents of a deceased Retiree are also eligible for Retiree coverage under the Plan as specified in the Retiree Coverage Eligibility Requirements section. In general, surviving Dependents will be subject to the Plan's usual eligibility and termination provisions without regard to any Participant- or Retiree-related provisions that could not apply.

Participant contributions for Retiree coverage will vary based on a Retiree's classification, years of service status with the Employer, and/or coverage election (Retiree-only coverage or Family coverage).

If a Retiree or a Retiree's Dependent becomes eligible for Medicare for any reason other than End Stage Renal Disease (ESRD), that individual must enroll for Medicare Part A and Part B at the first available opportunity to do so. If the individual is eligible for Medicare owing to ESRD, the Plan will remain the primary payer for the period of time prescribed by law until such time that Plan coverage is terminated for another reason. Upon the expiration of this period of time prescribed by law, coverage under the Plan will terminate.

The Employer should immediately be notified when a Covered Person becomes eligible for or enrolled in Medicare. A failure to notify the Employer of a change in Medicare eligibility or enrollment as soon as possible may result in the Plan Administrator determining that the Covered Person committed fraud or intentional misrepresentation in a claim for benefits and, accordingly, could result in an immediate termination of the Covered Person's coverage and/or the Covered Person may be asked to reimburse the Plan for any overpaid amounts.

As specified above, when a Retiree or a Retiree's Dependent spouse or child becomes eligible for Medicare due to age or disability, that individual must immediately notify the Employer of his or her Medicare eligibility or enrollment. Once the Employer is made aware of a Covered Person's Medicare eligibility or enrollment, coverage under the Plan for that person will then terminate as of the date of the first applicable event described below:

A. Enrollment in the Employer's Medicare Supplemental coverage/plan.

B. 90 days following the initial date the individual became eligible for Medicare but fails to enroll in Medicare during the Medicare Initial Enrollment Period (IEP) or the Medicare Special Enrollment Period (SEP).

C. At the expiration of Medicare's General Enrollment Period (GEP) if the individual fails to enroll during this period.

For an individual who enrolls in Medicare during an SEP or the GEP, the Retiree coverage provided under the Plan will continue until that individual is awarded Medicare A and B benefits as prescribed by Social Security Administration regulations.

The Employer reserves the right to amend Retiree coverage at any time.

A Participant may have participation extended under the Employer-provided extensions specified in the Schedule for Eligibility and Participation, under the FMLA, or under COBRA. A Long-Term Disability Leave Extension of Participation will typically coincide with the commencement of a COBRA extension of participation (if applicable) and will offset the length of a COBRA extension of participation; however, in the event that this Employer-provided extension of participation ever runs concurrently with an FMLA extension of participation, the COBRA extension of participation will proceed after the FMLA extension of participation ends. Any other Employer-provided extension of participation, including a Short-Term Disability Leave Extension of Participation, will apply before a COBRA extension of participation and will be in addition to the length of a COBRA extension of participation.

Notwithstanding any of the following provisions concerning extensions of participation, coverage for the Participant or the Participant's Dependent(s) may be immediately reduced or terminated by amendment to the Plan or termination of the Plan. If an event causing the Participant's or the Dependent's coverage to terminate also causes another extension of participation, a new extension period will begin for the Participant or the Participant's Dependent(s) on the date of such event.

Provided any required contributions are paid, coverage during an Employer-provided extension of participation shall be continued on the same basis as if the Participant had continued in Active Employment for the duration of the leave (note that Plan coverage may not be provided for the duration of an Employee's long-term disability leave, which can extend, if permitted by the Employer's policies, beyond the time period specified in Schedule for Eligibility and Participation).

EMPLOYER-PROVIDED EXTENSIONS OF PARTICIPATION

Short-Term Disability Leave Extension

Participation for a Participant and any eligible Dependents continues if the Participant suffers from Illness or Injury and has been granted a disability leave by the Employer's disability carrier under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved disability leave begins. However, if the Participant's disability leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation, the expiration of the approved disability leave or termination of employment, whichever occurs first.

Long-Term Disability Leave Extension

Participation for a Participant and any eligible Dependents continues if the Participant suffers from Illness or Injury and has been granted a disability leave by the Employer's disability carrier under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. Provided the Participant's approved disability leave continues, this extension of participation begins on the date immediately following the exhaustion of the time period

established for the Short-Term Disability Leave Extension of Participation as stated in the Schedule for Eligibility and Participation. If the Participant's disability leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation or the expiration of the approved disability leave, whichever occurs first.

Approved Leave of Absence Without Pay Extension

Participation for a Participant and any eligible Dependents continues if the Participant is granted an approved leave of absence (other than a disability leave described in the above paragraph) by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved leave of absence begins. However, if the Participant's approved leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation, the expiration of the approved leave of absence, or failure to pay required contributions, whichever occurs first.

Military Leave Dependent Extension

Participation for any eligible Dependents continues if the Participant goes on a military leave in accordance with the Employer's policies established by the Board of Commissioners' Resolution #08270. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation.

Parental Leave Extension

Participation for a Participant and any eligible Dependents continues if the Participant has been granted an approved parental leave of absence by the Employer under policies determined on a uniform, nondiscriminatory basis that precludes individual selection. This extension of participation begins on the date on which the Participant's approved parental leave of absence begins. However, if the Participant's approved parental leave of absence constitutes an FMLA leave, the extension of participation shall run concurrently with and will be offset against the length of an FMLA extension. The extension terminates upon the expiration of the time period stated in the Schedule for Eligibility and Participation or the expiration of the approved parental leave of absence, whichever occurs first.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

A Participant on leave under the FMLA may continue coverage during the leave on the same basis and at the same Participant contribution as if the Participant had continued in Active Employment continuously for the duration of the leave. Other provisions regarding an FMLA leave are set forth in the FMLA and the Employer's policy regarding the FMLA. If the Participant fails to return from the FMLA leave for any reason other than the continuation, recurrence, or onset of a "serious health condition" as defined in the FMLA or other circumstance considered by the Plan Administrator as beyond the control of the Participant, the

Employer may recover any Employer contribution paid to maintain coverage for the Participant during the leave. If a Participant fails to pay any required contribution for coverage during the FMLA leave within 30 days of the due date for the contribution, coverage shall be suspended upon 15 days advance written notification of the non-payment, subject to the right to reinstatement of coverage upon return to work from FMLA leave with no waiting period or other limitation normally applicable to a new Participant in the Plan.

COBRA AND USERRA EXTENSIONS OF PARTICIPATION

Certain individuals shall have the right to elect to continue coverage under this Plan upon the occurrence of a COBRA Qualifying Event or if the Participant goes on a military leave and the Uniformed Services Employment and Reemployment Rights Act (USERRA) mandates an extension of coverage. For more information on the COBRA and USERRA (military leave) extensions of participation, access the Employer's website at www.ocbenefits.com.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If another plan provides benefits in the form of service rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Claim Administrator may release to, and obtain from, any other insurer, plan, or party any information that it deems necessary for the purposes of this section. A Covered Person shall cooperate in obtaining information and shall furnish all information necessary to implement this provision.

In the event an individual is covered under the Plan as both a Participant and a Dependent, this Plan will be considered both the Primary Plan and the Secondary Plan for purposes of applying the Coordination of Benefits provision described in this section.

DEFINITIONS

The term "plan," as used in this section to refer to a plan other than this Plan, means any of the following providing benefits or services for health, medical, or dental care or treatment:

A. Group and nongroup insurance and subscriber contracts.

B. Health maintenance organization (HMO) contracts.

C. Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured).

D. Medical care components of long-term care contracts, such as skilled nursing care.

E. Health benefits under group or individual automobile contracts.

F. Health benefits under group or individual motorcycle contracts.

G. Medicare or any other federal governmental plan, as permitted by law.

The term "plan" as used in this section does not include any of the following:

A. Hospital indemnity coverage benefits or other fixed indemnity coverage.

B. Accident only coverage.

C. Specified disease or specified accident coverage.

D. Limited benefit health coverage, as defined by state law.

E. School accident-type coverage.

F. Benefits for non-medical components of long-term care policies.

G. Medicare supplement policies.

H. Medicaid policies.

I. Coverage under other federal governmental plans, unless permitted by law.

The term "Allowable Expense" means a health care expense, including deductibles, coinsurance and co-payments, that is covered at least in part by any plan covering the Covered Person. Any expense that is not covered by any plan covering the Covered Person is not an Allowable Expense. For example, the difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable Expense unless one of the plans provides coverage for private Hospital room charges. Further, the amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with that plan's provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

The term "Primary Plan" means the plan that pays benefits first. The Primary Plan must pay benefits in accordance with its terms without taking into consideration the existence of another plan.

The term "Secondary Plan" means any plan that pays benefits after the Primary Plan. The Secondary Plan may reduce benefits so that the payments from all plans do not exceed 100% of the total Allowable Expense.

COORDINATION OF BENEFITS PROCEDURE

The Coordination of Benefits Procedure determines how the benefits provided by the Plan will be coordinated with the benefits provided by any other plans covering a Covered Person for whom a claim is made.

The amount of expenses considered for benefits under this Plan, as a Secondary Plan, will only be the amount of eligible expenses not paid or reimbursed by the Primary Plan(s). Any expenses considered for benefits under this Plan are subject to all provisions stated in the Plan.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

Notwithstanding the Payment Priorities rules set forth below, the following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, this Plan shall be the Primary Plan and the automobile insurance shall be the Secondary Plan for purposes of paying benefits.

PAYMENT PRIORITIES

Each plan makes its claim payment in the following order, if Medicare is not involved (except as provided in paragraph C. below):

A. A plan that contains no provision for coordination of benefits, states that its coverage is primary, or does not have the same rules of priority as those listed below shall be the Primary Plan and pay before all other plans, including this Plan, and this Plan shall have only secondary liability.

B. Except as provided in paragraph C., a plan that covers the claimant other than as a dependent (e.g., as an employee or retiree) shall pay before the plan that covers the claimant as a dependent.

C. If the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is (1) secondary to a plan covering the claimant as a dependent and (2) primary to a plan covering the claimant other than as a dependent (e.g. as a retiree), then, with respect to the two non-Medicare plans, the order in paragraph B. is reversed so that:

   1. The plan covering the claimant as a dependent is primary and

   2. The plan covering the claimant other than as a dependent is secondary.

   In other words, in this situation, the plan covering the claimant as a dependent pays first, Medicare pays second, and the plan covering the person other than as a dependent pays third.

   See the Coordination With Medicare section for information regarding when this Plan is primary or secondary to Medicare under federal law.

D. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

1. If the dependent child's parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is the Primary Plan. If both parents have the same birthday, the plan that has covered the parent the longest is the Primary Plan. This process is known as the "birthday rule."

2. If the dependent child's parents are divorced or separated or are not living together, whether or not they have ever been married, payment shall be made as follows:

   a. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is the Primary Plan. This rule applies to plan years commencing after that plan is given notice of the court decree.

   b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the birthday rule will determine the order of benefits.

   c. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the birthday rule will determine the order of benefits.

   d. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

      i. The plan covering the custodial parent.

      ii. The plan covering the spouse of the custodial parent.

      iii. The plan covering the non-custodial parent.

      iv. The plan covering the spouse of the non-custodial parent.

      For this purpose, the custodial parent is the parent awarded custody of the child by court decree. In the absence of a court decree, the parent with whom the child resides more than one-half of the Calendar Year without regard to any temporary visitation shall be considered the custodial parent.

For purposes of this subsection, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

3. If the dependent child is covered under more than one plan of individuals who are not the parents of the child, the provisions of this subsection shall determine the order of benefits as if those individuals were the parents of the child.

E. The plan that covers the claimant as an active employee or dependent of an active employee shall pay before the plan that covers the claimant as an inactive employee (e.g., an employee who is laid off or retired) or dependent of such an inactive employee. This rule does not apply if the rules under paragraphs B. or C. can determine the order of benefits.

F. If a claimant has coverage provided under COBRA or under a right of continuation by state or other federal law ("continuation coverage") and also has coverage under another plan, the plan covering the claimant as an employee or retiree (or as the dependent of an employee or retiree) is the Primary Plan and the continuation coverage is the Secondary Plan. This rule does not apply if the rules under paragraphs B. or C. can determine the order of benefits.

G. Covered Persons eligible for Medicaid shall be subject to the following provisions with respect to a state Medicaid program:

1. The Plan will pay benefits with respect to a Covered Person in accordance with any assignment of rights made by or on behalf of the Covered Person under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid).

2. The Plan will not take into account the fact that an individual is eligible for or receives Medicaid assistance when considering eligibility for coverage or when determining or making benefit payments under the Plan.

3. To the extent payment has been made under Medicaid in any case in which the Plan has a legal liability for such payment, then payment under this Plan will be made in accordance with any state law that provides that the state has acquired the rights with respect to a Covered Person for such payment.

H. If the order set out in paragraphs A. through G. above does not apply in a particular case, the plan that has covered the claimant for the longest period of time shall pay first. To determine the length of time a person has been covered under a plan, two or more successive plans shall be treated as one plan if the claimant was eligible under the successor plan within 24 hours after the prior plan's coverage ended.

These coordination of benefit rules are intended to follow the National Association of Insurance Commissioners (NAIC) group coordination of benefits model regulation. The Plan's

coordination of benefit rules shall be interpreted accordingly. To the extent the NAIC model regulation is subsequently amended, the Plan's coordination of benefit rules shall be amended accordingly.

The Plan Administrator has the right to do the following:

A. Obtain from or share information with an insurance company or other organization regarding coordination of benefits, without the claimant's consent.

B. Require that the claimant provide the Plan Administrator with information regarding other plans in which the claimant may participate or be eligible to participate so that this provision may be implemented. A claimant's intentional nondisclosure under this provision shall constitute a misrepresentation in a claim for benefits for purposes of the Termination of Coverage section.

C. Pay the amount due under this Plan to an insurer or other organization if necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed becomes mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor the Trustee, if any, shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, the Employer, and Trustee, if any, shall not be liable to any person as the result of a payment made and shall be fully discharged from all future liability with respect to a payment made. Payments may be made in any one or more of the following ways, as determined by the Plan Administrator in its sole discretion:

A. Directly to the Covered Person or provider.

B. To the legal representative of the Covered Person or provider.

C. To a Close Relative or other relative by blood or marriage of the Covered Person or provider.

D. To a person with whom the Covered Person or provider resides.

E. By expending the amount directly for the exclusive benefit of the Covered Person or provider.

COORDINATION WITH MEDICARE

IMPORTANT: Individuals receiving Retiree coverage under the Plan who are eligible for Medicare (except as otherwise required by law when Medicare is due to End Stage Renal Disease [ESRD]) may not be eligible for coverage under this Plan (see the Retiree Coverage section on page 48 for Retiree coverage termination details).

The Plan must provide benefits in accordance with the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," that includes parts A and B of Subchapter XVIII of the Social Security Act, as amended, and any other applicable federal laws or regulations. If the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations, including allowing the Plan to become secondary to Medicare. As used in this section, the term "current employment status" has the same meaning as under 42 CFR § 411.104.

If a Covered Person is also eligible for Medicare, whether this Plan or Medicare is the primary payer depends upon the reason for the Covered Person's Medicare eligibility.

A. If the Medicare eligibility is because of Total Disability, this Plan will be the Primary Plan and Medicare the Secondary Plan if the Employer had 100 or more full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year and the Participant's coverage is based on current employment status.

   On the other hand, if the Employer had fewer than 100 full-time or part-time employees on 51% or more of its regular business days during the preceding Calendar Year, or if the Participant's coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree coverage), Medicare will be the Primary Plan and this Plan will be the Secondary Plan.

   If a Participant has a Dependent who is Totally Disabled, these same coordination of benefits rules will apply to the Dependent.

B. If the Medicare eligibility is because of End Stage Renal Disease (ESRD), this Plan will be the Primary Plan and Medicare the Secondary Plan – at least for the period of time prescribed by law.

C. If the Medicare eligibility is because the Participant or the Participant's Dependent spouse attains age 65, Medicare will be the Primary Plan and this Plan will be the Secondary Plan if the Participant's coverage is not based on current employment status (i.e., the Participant has terminated employment or lost coverage owing to a reduction in hours and is on COBRA or is receiving retiree coverage).

   On the other hand, if the Participant's coverage continues to be based on current employment status after attaining age 65, this Plan will be the Primary Plan and Medicare the Secondary Plan unless the Participant declines primary coverage under this Plan.

   If a Participant has a Dependent spouse who attains age 65, these same coordination of benefits rules will apply to the spouse.

D. For purposes of paragraphs A. and C., "Employer" includes any entity that is a member of Plan Sponsor's affiliated service group, as defined in Section 414(m)

of the Code, and any entity that is at least 50% commonly owned with Plan Sponsor as defined in subsections (a) or (b) of Section 52 of the Code. If, as a result of the rules under paragraphs A., B., or C. of this section, Medicare is secondary to a plan covering the Covered Person as a Dependent and primary to a plan covering the Covered Person other than as a Dependent (e.g., as a retiree), then the rule under paragraph C. of the Payment Priorities section shall determine the order of the benefits.

As stated above, federal law prescribes these rules; if the applicable laws or regulations are changed, the Plan is automatically amended to conform to such laws or regulations. See the Plan Administrator for details.

PLAN'S RIGHT TO REIMBURSEMENT AND SUBROGATION RIGHT

Plan's Right to Reimbursement

If the Plan pays benefits and another party (other than the Covered Person or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement that entitles it to recover from the Covered Person or another party 100% of the amount of benefits paid by the Plan to or on behalf of the Covered Person.

The Plan's right to 100% reimbursement applies to the following:

A. Not only to any recovery the Covered Person receives or is entitled to receive from the other party but also to any recovery the Covered Person receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.

B. To any recovery from the Covered Person's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.

C. To any recovery, even if the other party is not found to be legally at fault for causing the Covered Person to incur the expenses paid or payable by the Plan.

D. To any recovery, even if the damage recovered or recoverable from the other party, its insurer or plan, or the Covered Person's policy is not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.

E. To any recovery, regardless of whether the recovery fully compensates the Covered Person for his or her Injuries and Illnesses and regardless whether the Covered Person is made whole by the recovery.

F. To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the Covered Person's attorney's fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the Covered Person's attorney's fees or costs in obtaining the

recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

Plan's Subrogation Right to Initiate Legal Action

If a Covered Person does not bring an action against the other party who caused the need for the benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan shall be responsible for its own attorney's fees.

Cooperation of Covered Person

A Covered Person shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan. This includes assigning the Covered Person's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan.

Plan's Right to Withhold Payment

The Plan may withhold payment of benefits when it appears that a party other than the Covered Person or the Plan may be liable for the expenses until such liability is legally determined. Further, as a precondition to paying benefits when it appears that the need for the benefits payable by the Plan was caused by another party, the Plan may withhold the payment of benefits until the Covered Person signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right.

Preconditions to Participation and the Receipt of Benefits

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

A. The Covered Person agrees not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.

B. The Covered Person agrees not to raise any jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

C. The Covered Person specifically acknowledges the Plan's fiduciary right to bring an equitable reimbursement recovery action should the Covered Person obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any property or recovery to the extent of the expenses payable by the Plan.

D. The Covered Person specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The Covered Person consents to such intervention.

E. The Covered Person specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the Covered Person from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan's right to reimbursement is fully satisfied. The Covered Person consents to such injunctive relief.

Notice and Settlement of Claim

A Covered Person shall give the Claim Administrator written notice of any claim against another party as soon as the Covered Person becomes aware that he may recover damages from another party. A Covered Person shall be deemed to be aware that he may recover damages from another party upon the earliest of the following events:

A. The date the Covered Person retains an attorney in connection with the claim.

B. The date a written notice of the claim is presented to another party or the other party's insurer or attorney by the Covered Person or by the Covered Person's insurer or attorney.

A Covered Person shall not compromise or settle any claim against another party without the prior written consent of the Claim Administrator. If a Covered Person fails to provide the Claim Administrator with written notice of a claim as required in this section, or if a Covered Person compromises or settles a claim without prior written consent as required in this section, the Claim Administrator shall deem the Covered Person to have committed fraud or misrepresentation in a claim for benefits and accordingly, shall terminate the Covered Person's participation in the Plan.

PROVISIONAL PAYMENT OF DISPUTED CLAIM

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Claim Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan's rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

CLAIMS PROCEDURE

NOTE: The law that governs the Plan's claims procedures (as summarized in this section) has also established separate processing guidelines for urgent care claims and pre-service claims. As the law defines these types of claims, the Plan currently operates in a manner that would not generate such claims and, accordingly, the details of these specific processing guidelines have been omitted from this section. However, in the event the Plan is ever operated in a manner that subjects the Plan to these guidelines, the Plan will process claims in accordance with the governing law.

NOTICE AND PROOF OF CLAIM

Written notice of Injury or Illness upon which a claim may be based should be given to the Claim Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such Injury or Illness may be claimed, or as soon as reasonably possible. The written notice must identify the claimant and the nature of the Injury or Illness. **Failure to provide notice within 24 months following when the first loss occurred for which benefits arising out of such Injury or Illness may be claimed shall invalidate the claim**. However, this time limit shall not apply where the reason for the delay was the failure of a third-party provider to supply evidence necessary to provide the notice or caused by some other circumstance outside the claimant's control.

The Claim Administrator, upon receiving the notice required by the Plan, will provide the claimant with any forms necessary for filing a proof of loss. If the Claim Administrator does not provide the necessary forms within 15 days after receiving such notice, the claimant can meet the requirements of the Plan regarding proof of loss by submitting (within the time frame fixed in the Plan for filing proofs of loss) written proof of the occurrence, character, and extent of the loss for which the claim is made.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination. This appointment must be in writing on a form designated by the Plan.

EXAMINATION AND RELEASE OF MEDICAL INFORMATION

The Claim Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pendency of a claim. The Claim Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary medical information and records in order to process a claim.

INITIAL DECISION

The Claim Administrator will notify a claimant of the Plan's benefit determination as follows:

A. Post-Service Claims. A post-service claim is a claim for a benefit that is not a pre-service claim or an urgent care claim. If the Claim Administrator denies a post-service claim, in whole or in part, it shall notify the claimant of the adverse determination within 30 days after receipt of the claim. The Claim Administrator may extend this period one time for up to 15 days, if it determines that such an extension is necessary owing to matters beyond its control. The Claim Administrator must notify the claimant, before the expiration of the initial 30-day period, of the circumstances requiring the extension and the date it expects to make a decision. If the extension is necessary because the claimant failed to submit the information required to decide the claim, the notice of extension shall describe this required information, and the claimant will be granted 45 days from the receipt of the notice to provide the information. The Claim Administrator will

have 15 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Claim Administrator may issue a denial of the claim within 15 days after the expiration of the 45-day period.

B. Concurrent Care Claims. A concurrent care claim is a claim approved by the Claim Administrator for an ongoing course of treatment to be provided over a period of time or over a number of treatments. If the Claim Administrator reduces or terminates that course of treatment (other than by Plan amendment or termination), it has issued an adverse benefit determination. The Claim Administrator will provide notice, in accordance with the Benefit Determination Notice section below, at least 30 days before reducing or terminating the course of treatment in order to give the claimant time to appeal the reduction or termination. However, special rules apply in the case of a course of treatment for urgent care. The Claim Administrator shall decide any request to extend a course of treatment for urgent care as soon as possible and shall notify the claimant of its determination within 24 hours (if the claimant makes the claim to the Claim Administrator at least 24 hours before the expiration of the prescribed course of treatment for urgent care).

BENEFIT DETERMINATION NOTICE

The Claim Administrator will provide the claimant with a written or electronic notification of any adverse benefit determination. An adverse benefit determination includes a denial of the claim, in whole or in part, including a partial payment of a claim. The notice will set forth the reason or reasons for the adverse determination, and refer to the Plan provisions on which the determination is based. The notice will also describe the Plan's review procedures and related time limits, and will include a statement of the claimant's right to bring a civil action following an adverse benefit determination on review. It should be noted that because the Plan is not subject to ERISA, the claimant's right to bring a civil action is not governed nor protected under Section 502(a) of ERISA.

If the Claim Administrator based the adverse benefit determination upon an internal rule, guideline, protocol, or other similar criterion, the notice will state that the Claim Administrator relied upon this information and that it will provide a free copy of the same to the claimant upon request. If the Claim Administrator based the adverse benefit determination on a Medically Necessary, Experimental treatment, or similar exclusion or limit, the notice will state that the Claim Administrator will provide an explanation of the determination free of charge to the claimant upon request.

APPEAL OF DENIAL

The claimant may request a review of an adverse benefit determination by submitting a written application to the Claim Administrator within 180 days following the denial of the claim. The resubmission of a claim by the claimant that has been processed by the Plan and paid or denied (in full or in part) will be considered an appeal. The claimant may submit written comments, documents, records, and other information relating to the claim. The Claim Administrator will

consider the information without regard to whether it was submitted or considered in the initial benefit determination. In filing the appeal, the Claim Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant if the Claim Administrator relied upon it in making the benefit determination; if it was submitted, considered, or generated in the course of making the benefit determination; or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The appeal procedure will provide for a review that does not defer to the initial adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment (including a determination of whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the initial adverse benefit determination or a subordinate of that person. The Claim Administrator shall identify any medical or vocational experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

FINAL DECISION

The Claim Administrator shall make a decision regarding a request for review as detailed in this subsection.

There shall be two levels of appeal for post-service claims. The Claim Administrator shall notify the claimant of its determination regarding a first-level appeal within 30 days after receipt of the claimant's request for a review of an adverse benefit determination. A claimant whose first level of appeal is denied may submit a second level appeal to the Claim Administrator in writing within 60 days following the denial of the first level appeal. If the claimant submits a second appeal, the Claim Administrator shall notify the claimant of its determination regarding a second-level appeal within 30 days after receipt of the claimant's request of a second-level review of an adverse benefit determination.

The Claim Administrator shall provide a claimant with written or electronic notification of its determination on review. The notice shall include the same information that was required in the notification of the initial adverse benefit determination. The decision of the Plan Administrator on appeal shall be final and binding.

The claim and appeal procedures for the Plan are governed exclusively by the provisions set forth above. Accordingly, the claim and appeal procedures of any network provider, third party administrator, insurer, or other plan shall not control. The claim and appeal procedures comply with all applicable state and federal requirements.

SPECIAL RULES

In accordance with Health Care Reform, claimants will be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination, the claimant must be provided, free of charge, with new or additional evidence considered, relied upon, or generated by the Plan in connection with a claim, as well as any new or additional rationale of the adverse benefit determination. Further, the claimant must be provided with a reasonable opportunity to respond to the new or additional evidence or rationale.

C. The Plan cannot base decisions regarding the hiring, compensation, termination, or promotion of a claims adjudicator, medical expert, or similar individual upon the likelihood that the individual will support the Plan's denial of benefits.

D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if ten percent or more of the population residing in the claimant's county are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning, any standard used in denying the claim, and a description of the available internal appeals and external review processes.

E. The Legal Proceedings subsection states that no court action may be brought by a claimant until exhausting the Claims Procedure provisions of the Plan. If the Plan fails to strictly adhere to the internal claim and appeal procedures prescribed by Health Care Reform, the claimant is deemed to have exhausted the internal claim and appeal procedures. As a result, the claimant may initiate an external review and/or file a legal proceeding. However, this rule shall not apply to minor, de minimis violations.

F. A Plan must offer an external review process. The Plan may be subject to the applicable state external review process for fully-insured health plans and non-ERISA self-funded health plans. Otherwise, the Plan will offer an external review procedure which satisfies U.S. Department of Labor regulations. Information about the external review process is as follows:

   1. The primary type of external review is a standard external review. A claimant must file a request for a standard external review within four

months after the date of receipt of a notice of adverse benefit determination or final internal adverse benefit determination.

2. Within five business days following the date of receipt of the external review request, the Plan must complete a preliminary review of the request to determine whether all of the following has occurred:

   a. The claimant had coverage under the Plan at the time the service or supply was provided.

   b. The claimant has exhausted the Plan's internal appeal process unless not required to do so as described above.

   c. The claimant has provided all information and forms necessary to process the external review.

3. Within one business day after completing the preliminary review, the Plan will issue a written notification to the claimant. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In such case, the Plan will allow the claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notification, whichever is later.

4. If the Plan determines that an adverse benefit determination or final internal adverse benefit determination is eligible for external review, the Plan shall assign the external review to an independent review organization ("IRO") that is accredited by URAC or by a similar nationally recognized accrediting organization. The Plan shall take action against bias and to ensure independence. The Plan shall have contracts in place with at least three IROs, and external reviews shall be rotated among the IROs. External reviews shall be rotated among the IROs. In addition, an IRO shall not be eligible for any financial incentive based on the likelihood that the IRO will support the denial of benefits. The IRO shall follow the procedure below:

   a. The assigned IRO will notify the claimant in writing of the request's eligibility and acceptance for external review. In order to be eligible for external review, the adverse benefit determination or final internal adverse benefit determination must involve a medical judgment or rescission of coverage. The IRO shall make this determination when considering the request's eligibility for external review. If accepted, the notice will include a statement that the claimant may submit in writing to the IRO within ten business days following the date of receipt of the notice additional

information for the IRO to consider when conducting the external review.

b. Within five business days after the date of the assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan.

c. Upon any receipt of any information submitted by the claimant, the IRO must, within one business day, forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination. The external review may be terminated as a result of the reconsideration only if the Plan reverses its adverse benefit determination or final internal adverse benefit determination and provides coverage or payment. Within one business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO shall terminate the external review upon receipt of the notice from the Plan.

d. The IRO will review all the information and documents timely received. In reaching a decision the assigned IRO will review the claim "de novo" (i.e., anew) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider additional documents and information in conducting the external review, including the claimant's medical records; the attending health care professional's recommendation; reports from appropriate health care professionals; other documents submitted by the Plan, claimant, or claimant's treating provider; the terms of the Plan; appropriate practice guidelines (including applicable evidence-based standards); any applicable clinical review criteria developed and used by the Plan, unless inconsistent with the terms of the Plan or applicable law; and the opinion of the IROs clinical reviewer(s).

e. The IRO must provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. The IRO must deliver the notice of its final external review decision to the claimant and the Plan.

f. The IRO's decision notice will contain a general description of the reason for the request for external review, including information sufficient to identify the claim (including the date[s] of service, the health care provider, the claim amount [if applicable], the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial), the date that the IRO received the assignment to conduct the external review, the date of the IRO decision, references to the evidence or documentation considered in reaching its decision, a discussion of the principal reason(s) for its decision, a statement that the determination is binding except to the extent that other remedies may be available under state or federal law, a statement that judicial review may be available, and current contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act.

g. After a final external review, the IRO must maintain records of all claims and notices associated with the external review for six years. The IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

5. Upon receipt of a notice of final external review reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment in connection with the claim.

6. The second type of external review is an expedited external review. The Plan must allow a claimant to make a request for an expedited external review in two situations. First, an expedited external review is available where the claimant has received an adverse benefit determination and it involves a medical condition of the claimant for which the time frame for completing an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited external appeal. Second, an expedited external review is available where the claimant has received a final internal adverse benefit determination and the claimant has a medical condition where the time frame for completing a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged for a facility. The Plan and the IRO shall follow the procedure below for an expedited external review:

a. Immediately upon the receipt of a request for an expedited external review, the Plan must determine whether the request meets the review ability requirements set forth above for a standard external review. The Plan must immediately send a written notice that meets the requirements set forth above for a standard external review to the claimant regarding its eligibility determination.

b. Upon a determination that the request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for a standard external review. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse determination to the assigned IRO electronically, by telephone, by facsimile, or by any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents under the same procedures for a standard external review. In reaching a decision, the IRO must review the claim "de novo" (i.e., anew) and is not bound by any decisions or conclusions reached during the Plan's internal claim and appeals process.

c. The IRO shall provide notice of its decision in the same manner as a standard external review and shall do so as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

LEGAL PROCEEDINGS

No action at law or in equity shall be brought by a claimant to recover a claim on the Plan before the exhaustion of remedies provided under the Claims Procedure provisions of the Plan, nor shall such action be brought at all, unless brought by the last day of the Plan Year after the Plan Year in which the claimant was provided with a written notice denying the final level of Plan appeal concerning the claim.

NO INTEREST

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

UNCLAIMED PROPERTY / ESCHEAT

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

CLAIM PROCEDURES FOR DISABILITY-BASED CLAIM DETERMINATIONS

If a claim for Plan benefits with respect to an adult Dependent child is denied because it is determined that the child does not satisfy all the requirements to be considered disabled for purposes of the Plan (a "disability claim"), the claimant will have additional appeal rights in accordance with the U.S. Department of Labor regulations. This subsection shall apply in this instance.

Notice and Proof of Claim

The Claim Administrator will provide the claimant with any forms necessary for filing a claim. Written notice of Injury or Illness upon which a claim may be based should be given to the Claim Administrator within 30 days of the date on which the first loss occurred for which benefits arising out of such Injury or Illness may be claimed, or as soon as reasonably possible. **Failure to provide notice within 12 months following the end of the Plan Year during which the first loss occurred for which benefits arising out of such Injury or Illness may be claimed shall invalidate the claim**. However, this time limit shall not apply where the reason for the delay was the failure of a third-party provider to supply evidence necessary to provide the notice or caused by some other circumstance outside the claimant's control.

A claimant may appoint an authorized representative to act on his or her behalf in pursuing a benefit claim or in appealing an adverse benefit determination. This appointment must be in writing on a form designated by the Plan.

Examination and Release of Medical Information

The Plan Administrator shall have the right and opportunity to have a claimant examined whenever and as often as reasonably required during the pendency of a claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where not forbidden by law. Further, as a condition of receiving benefits under the Plan, the claimant authorizes the release of all necessary medical information and records in order to process a claim.

Initial Decision

The Claim Administrator will notify a claimant of the Plan's benefit determination. If a disability claim is denied, in whole or in part, the Claim Administrator must notify the claimant of the adverse benefit determination within a reasonable period of time, but no longer than 45 days after receipt of the claim. The Claim Administrator may extend this period for up to 30 days, if it determines that such an extension is necessary owing to matters beyond its control, including situations in which the claim for benefits is incomplete.

The Claim Administrator must notify the claimant, before the expiration of the initial 45-day period, of the circumstances requiring the extension and the date it expects to make a decision. The Claim Administrator may prolong this first 30-day extension period for up to 30 additional days, if it determines that the additional time is necessary owing to matters beyond its control. The Claim Administrator must notify the claimant, before the expiration of the first 30-day extension period, of the circumstances requiring the second extension and the date it expects to make a decision.

Any extension notice must include an explanation of the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim (i.e., the reason for the extension), and the additional information needed to resolve those issues (if applicable).

The claimant will be granted 45 days to provide the required information. The Claim Administrator will have 30 days from the date it receives this information from the claimant to make the benefit determination. If the claimant does not provide this information within 45 days from the receipt of the notice of extension, the Claim Administrator may issue a denial of the claim within 30 days after the expiration of the 45-day period.

An adverse benefit determination includes a denial of the claim, in whole or in part, including a partial payment of a claim. The Claim Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection). In addition, the notice must include the following:

A. A description of any additional material or information necessary for the claimant to perfect the claim for benefits and an explanation of why such material or information is necessary.

B. A description of the Plan's review procedures and related time limits applicable to such procedures.

Appeal of Adverse Benefit Determination

In filing an appeal (either the first-level or the voluntary second-level appeal), the Claim Administrator will provide the claimant, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, a document, record, or other information is relevant to the claim for benefits as follows:

A. It was relied upon in making the adverse benefit determination.

B. It was submitted, considered, or generated in the course of making the adverse benefit determination, regardless of whether it was relied upon in making the adverse benefit determination.

C. It demonstrates compliance with the administrative processes and safeguards used to verify that benefit claim determinations are made in accordance with the Plan's terms, and where appropriate, the Plan's terms have been applied consistently with respect to similarly situated claimants.

D. It constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, regardless of whether such policy or guidance was relied upon in making the adverse benefit determination.

The appeal procedure will provide for a review that does not defer to the previous adverse benefit determination. The appeal will be conducted by an appropriately named fiduciary of the

Plan who is neither the individual who made the previous adverse benefit determination nor a subordinate of that individual. If the appeal is based in whole or in part on a medical judgment (including a determination of whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate), the appropriately named fiduciary will consult with a health care professional who has proper training and experience in the relevant field of medicine. The health care professional reviewing the appeal will not be the person who was consulted in the previous adverse benefit determination or a subordinate of that person. The Claim Administrator shall identify any medical or vocational experts it consulted on behalf of the Plan regarding a claimant's adverse benefit determination, whether or not it relied upon their advice.

First Level of Appeal

The claimant may request a review of the initial adverse benefit determination by submitting a written application to the Claim Administrator within 180 days following the initial adverse benefit determination. The claimant may submit written comments, documents, records, and other information relating to the claim. The Claim Administrator will consider the information without regard to whether it was submitted or considered in the initial benefit determination.

The Claim Administrator will notify the claimant of its determination on review regarding a disability claim within 45 days after receipt of the claimant's request for a review of the initial adverse benefit determination. The Claim Administrator may extend this period one time for up to 45 days if it determines that special circumstances require an extension of the time for processing the claim. The Claim Administrator must notify the claimant, before the expiration of the initial 45-day period, of the special circumstances requiring an extension and the date that it expects to make its decision.

The Claim Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination on review that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection).

Voluntary Second Level of Appeal

The claimant may request a review of the adverse benefit determination on review (i.e., a second-level appeal) by submitting a written application to the Claim Administrator within 60 days following the adverse benefit determination on review (i.e., the first-level appeal). The claimant may submit written comments, documents, records, and other information relating to the claim. The Claim Administrator will consider the information without regard to whether it was submitted or considered in a previous adverse benefit determination.

The Claim Administrator will notify the claimant of its determination on review regarding the disability claim within 45 days after receipt of the claimant's request for a review of the previous adverse benefit determination. The Claim Administrator may extend this period one time for up to 45 days if it determines that special circumstances require an extension of the time for processing the claim. The Claim Administrator must notify the claimant, before the expiration of the initial 45-day period, of the special circumstances requiring an extension and the date that it expects to make its decision.

The Claim Administrator must provide the claimant with a written or electronic notification of any adverse benefit determination on review that satisfies the requirements below (see the Adverse Benefit Determination Notice subsection).

Adverse Benefit Determination Notice

Any adverse benefit determination notice must be provided in a culturally and linguistically appropriate manner and include the following:

A. The specific reason or reasons for the adverse benefit determination.

B. A reference to the specific Plan provisions on which the adverse benefit determination is based.

C. A discussion of the Claim Administrator's decision, including an explanation of the basis for disagreeing with the following:

1. The views presented by the claimant of health care professionals treating the claimant and vocational professionals who evaluated the claimant.

2. The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, regardless of whether the Claim Administrator relied upon this advice in making the adverse benefit determination.

3. A disability determination presented by the claimant made by the Social Security Administration.

D. An explanation of the scientific or clinical judgment for the adverse benefit determination or a statement that such explanation will be provided free of charge upon request, applying the terms of the Plan to the claimant's medical circumstances, if the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit.

E. The specific internal rules, guidelines, protocols, standards, or similar criteria of the Plan that were relied upon by the Plan in making an adverse benefit determination, or a statement that such internal rules, guidelines, protocols, standards, or similar criteria of the Plan do not exist.

F. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits. For this purpose, the determination of whether a document, record, or other information is relevant to the claim for benefits is based on the same four factors listed above (see the Appeal of Adverse Benefit Determination subsection).

Special Rules

Claimants will be provided with the following additional rights with respect to claims and appeals:

A. A claimant has the right to appeal an adverse benefit determination under the Plan, which includes a denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit. In addition, a rescission of coverage is considered an adverse benefit determination for this purpose. As a result, a claimant has the right to appeal a rescission of coverage under the Plan.

B. In connection with the appeal of an adverse benefit determination (either the first-level or the voluntary second-level appeal), the claimant must be provided, free of charge, with the following:

1. New or additional evidence considered, relied upon, or generated by the Plan in connection with the claim.

2. New or additional rationale on which the adverse benefit determination is based.

The claimant must be provided with this new or additional information as soon as possible and sufficiently in advance of the date the Plan issues an adverse benefit determination on review so that the claimant has a reasonable opportunity to respond to the new or additional information before such date.

C. The Plan cannot base decisions regarding the hiring, compensation, termination, promotion, or other similar matters with respect to any individual (e.g., a claims adjudicator, medical expert, or vocational expert) upon the likelihood that the individual will deny a claim for benefits or support the Plan's denial of benefits on review.

D. Certain benefit determination notices and appeal notices may be required to be provided in a language other than English if ten percent or more of the population residing in the claimant's county are literate only in that other language. Further, the notices must include additional information such as information sufficient to identify the claim involved, the denial code and its corresponding meaning, any standard used in denying the claim, and a description of the available appeal and review processes.

Legal Proceedings

No action at law or in equity shall be brought by a claimant to recover a denied claim against the Plan before the exhaustion of remedies provided under the Claims Procedure provisions of the Plan. The claimant is not required to request a voluntary second-level appeal before bringing a lawsuit to recover a denied claim. However, a claimant may not bring any legal action to recover a denied claim, unless it is brought by the last day of the Calendar Year after the

Calendar Year in which the claimant was provided with the initial written denial notice concerning the claim.

No Interest

The Plan shall not be required to pay interest on any claim for Plan benefits regardless of when paid.

Unclaimed Property / Escheat

If a check for the payment of Plan benefits is not negotiated within one year after the date it is issued, the check shall be dishonored.

COMPLIANCE WITH HIPAA PRIVACY AND SECURITY RULES

PERMITTED AND REQUIRED USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Subject to obtaining written certification pursuant to the Certification of the Plan Sponsor provision (see below), the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor does not use or disclose that PHI except for the following purposes:

A. To perform Administrative Functions for the Plan.

B. To obtain premium bids from insurance companies or other health plans for providing coverage under or on behalf of the Plan.

C. To modify, amend, or terminate the Plan.

Notwithstanding the provisions of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 CFR § 164.504(f).

CONDITIONS OF DISCLOSURE

The Plan Sponsor agrees to the following in regard to any PHI:

A. To not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

B. To ensure that any agents, including subcontractors, 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 PHI.

C. To not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan.

D. To report to the Plan any known use or disclosure of the information that is inconsistent with the uses or disclosures permitted.

E. To make a Covered Person's PHI available when he or she requests access in accordance with 45 CFR § 164.524.

F. To make a Covered Person's PHI available when he or she requests an amendment to same, and to incorporate any amendments to that PHI in accordance with 45 CFR § 164.526.

G. To make available the information required to provide an accounting of disclosures of PHI to a Covered Person upon request in accordance with 45 CFR § 164.528.

H. To make its internal practices, books, and records relating to the use and disclosures of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services in order to determine compliance by the Plan with the HIPAA privacy rules.

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

J. To ensure that the adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 164.504(f)(2)(iii), is satisfied and that terms set forth in the applicable provision below are followed.

To be compliant with the HIPAA security standards, the Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/termination information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI. The Plan Sponsor shall ensure that any agents (including Business Associates and subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor shall report to the Plan any security incident of which it becomes aware.

CERTIFICATION OF PLAN SPONSOR

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Plan Sponsor provided that the Plan Sponsor uses such Summary Health Information only for the following purposes:

A. To obtain premium bids from health plan providers to provide health coverage under the Plan.

B. To modify, amend, or terminate the Plan.

ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

The Plan Sponsor will provide access to PHI to the employees or classes of employees listed in its HIPAA privacy policies and procedures. The Plan Sponsor will restrict the access to and use of PHI by these individuals to the Administrative Functions that the Plan Sponsor performs for the Plan. In the event any of these individuals do not comply with the provisions of the Plan relating to use and disclosure of PHI, the Plan Sponsor will impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will impose such sanctions progressively (e.g., an oral warning, a written warning, time off without pay, and termination), if appropriate, and commensurate with the severity of the violation.

To comply with the HIPAA security rule, the Plan Sponsor shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the authorized employees or classes of employees have access to electronic PHI.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION

Pursuant to 45 CFR § 164.504(f)(1)(iii), the Plan may disclose information on whether an individual is enrolled in or has terminated from the Plan to the Plan Sponsor.

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

In accordance with the HIPAA privacy rules, the Plan Sponsor authorizes and directs the Plan to disclose PHI to stop-loss carriers, excess-loss carriers, or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess-loss coverage related to benefit claims under the Plan.

OTHER USES AND DISCLOSURES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the HIPAA privacy rules.

PARTICIPANT NOTIFICATION

Participants shall be notified of the Plan's compliance with the HIPAA privacy rules in a Notice of Privacy Practices.

PLAN ADMINISTRATOR

The Plan Administrator is charged with the administration of the Plan. The Plan Administrator shall have the discretionary authority to decide all questions of eligibility for participation and eligibility for benefit payments and to determine the amount and manner of payment of benefits. The Plan Administrator shall exercise its discretion in a uniform and consistent manner, based upon the objective criteria set forth in the Plan. Further, the Plan Administrator shall have the discretionary authority to construe and interpret the terms of the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions. The Plan Administrator may delegate all or a portion of its duties under the Plan to one or more authorized officers and/or an administrative committee and may utilize the services of the Claim Administrator to assist with performing claim payment and other various administrative functions of the Plan.

AMENDMENTS AND TERMINATION

The Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

A. The Plan Sponsor shall have the right to amend this Plan at any time, in whole or in part, to take effect retroactively or otherwise. No amendment may retroactively reduce claims for any Covered Expenses that were incurred before the amendment unless necessary to conform the Plan to the requirements of the Code, regulations issued under the Code, and any other applicable laws or regulations.

B. The Plan Sponsor reserves the right at any time to terminate the Plan by action of the Board of Commissioners or other similar governing body of the Plan Sponsor.

In addition, the Plan shall automatically terminate upon the occurrence of any of the following events:

A. The adjudication of the Plan Sponsor as bankrupt.

B. A general assignment by the Plan Sponsor to or for the benefit of one or more of its creditors.

C. The merger or consolidation of the Plan Sponsor to another entity that is the surviving entity.

D. The consolidation or reorganization of the Plan Sponsor.

E. The sale of substantially all of the assets of the Plan Sponsor, unless the successor or purchasing entity adopts the Plan within 90 days thereafter.

If termination occurs, the Plan shall pay all benefits for Covered Expenses incurred before the termination date. Covered Persons shall have no further rights under the Plan.

FREE CHOICE OF PHYSICIAN

The Covered Person shall have free choice of any legally qualified Physician or surgeon.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law or regulation to which it is subject, that provision is deemed amended to conform to such law or regulation.

FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at any other time, nor will such failure affect the right to enforce any other provision.

ENTIRE REPRESENTATION / NO ORAL MODIFICATIONS

This single document sets forth the terms of the Plan and the Summary Plan Description and it supersedes all other documents. Any other descriptive or interpretive materials (such as benefit summaries) shall not change the terms of the Plan as set forth in this document. Further, the terms of the Plan may not be modified by any oral statements made by the Employer or any of its directors, officers, Employees, agents, or authorized representatives, including, but not limited to, the Claim Administrator.

NO VESTING

There is no vested right to current or future benefits under this Plan. A Covered Person's right to benefits is limited to any Plan assets and to Covered Expenses incurred and submitted within the time limits set forth in the Claims Procedure provision and incurred and submitted before the earliest of the following:

A. An amendment to the Plan that limits or terminates such benefits.

B. Termination of the Plan.

C. Termination of coverage or participation.

NON-ASSIGNABILITY

The benefits payable under the Plan to a Covered Person are specific to the Covered Person and may be received only by the Covered Person. No benefits of the Plan shall be assigned to any person, corporation, entity, or party except for assignment to the federal government in

accordance with back-up withholding laws or except as provided in accordance with any assignment of rights as required by a state Medicaid program and in accordance with any state law that provides that the state has acquired the rights to payment with respect to a Covered Person. Any other attempted assignment shall be void. However, the Plan reserves the right to make payment of benefits, in its sole discretion, directly to a provider of services or the Covered Person. The Plan reserves the right, in its sole discretion, to refuse to honor the assignment of any claim to any person, corporation, entity, or party. This section shall not be interpreted to prevent direct billing for Covered Expenses by a provider to the Plan Administrator.

NO EMPLOYMENT RIGHTS

The establishment and maintenance of this Plan shall not be construed as conferring any legal rights on any Employee to be continued in the employ of the Employer, nor shall this Plan interfere in any way with the right of the Employer to discharge any Employee.

COVERED PERSONS' RIGHTS

Except as may be required by law, the establishment of this Plan and the Trust, if any, shall not be construed as giving any Participant or Dependent any equity or other interest in the assets, business, or affairs of the Employer; or the right to question or complain about any action taken by its officers, directors, or stockholders or about any policy adopted or followed by the Employer; or the right to examine any of the books and records of the Employer. The rights of all Participants and Dependents shall be limited to their right to receive payment of their benefits from the Plan when the same becomes due and payable in accordance with the terms of the Plan.

ACTS OF PROVIDERS

Nothing contained in this Plan shall confer upon a Covered Person any claim, right, or cause of action, either at law or in equity, against this Plan for the acts of any provider (e.g., Hospital, Physician, nurse, pharmacist, etc.) from which the Covered Person receives services or care while covered under this Plan.

RECOVERY OF OVERPAYMENT

If the Plan pays benefits that should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Claim Administrator shall have the right to recover such payment or excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

ACCEPTANCE / COOPERATION

Accepting benefits under the Plan means that the Covered Person has accepted the Plan's terms and shall be obligated to cooperate with the Plan Administrator's requests to help protect the Plan's rights and carry out its provisions.

Certain words and phrases used in this Plan are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan. Where these terms are used elsewhere in the Plan with the meanings assigned to them below, the terms usually will be capitalized, and where these terms are used with their common, non-technical meanings, the terms usually will not be capitalized (except when necessary for proper grammar).

ACCIDENT; ACCIDENTAL

The term "Accident" or "Accidental" means a bodily Injury sustained independently of all other causes that is sudden, direct, and unforeseen, and is exact as to time and place. Lifting, bending, stooping, simple exertion, etc., are not, in themselves, Accidental events.

ACTIVE EMPLOYMENT

The term "Active Employment" means the Participant is an Employee who is eligible for Plan benefits and not terminated from employment with Oakland County.

ADDICTIONS TREATMENT (ALCOHOLISM, DRUG ABUSE, OR SUBSTANCE ABUSE)

The term "Addictions Treatment" means the diagnosis, care, and treatment of alcoholism, drug abuse, or substance abuse (the taking of alcohol or other drugs or substances at dosages that place a Covered Person's welfare at risk and/or cause the Covered Person to endanger the public welfare).

ADMINISTRATIVE FUNCTIONS

The term "Administrative Functions" means 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. Administrative Functions include quality assurance, employee assistance, claims processing, auditing, monitoring, and management of carve-out-benefits, such as vision and dental. PHI for these purposes may not be used by or between the Plan or Business Associates in a manner inconsistent with the HIPAA privacy rules, absent an authorization from the individual. Administrative functions specifically do not include any employment-related functions.

ANNUAL OPEN ENROLLMENT PERIOD

The term "Annual Open Enrollment Period" means the period during the year for making elections under the Plan. The beginning and ending dates of each Annual Open Enrollment Period shall be determined by the Employer and communicated to Participants.

BEHAVIORAL CARE

The term "Behavioral Care," also known as psychoanalytic care or psychiatric care, means treatment for a Mental Illness or Disorder, a Functional Nervous Disorder, or for Addictions Treatment.

BIRTHING CENTER

The term "Birthing Center" means a facility that meets all of the following criteria:

A. Is licensed as a Birthing Center by the appropriate jurisdiction.

B. Is set-up, equipped, and run solely as a setting for prenatal care, delivery, and immediate postpartum care.

C. Charges fees for the services and supplies that it provides.

D. Is under the direction of at least one M.D. or D.O. specializing in obstetrics and gynecology.

E. Has an M.D. or D.O. present at all births and during the immediate postpartum period.

F. Extends staff privileges to Physicians who have privileges to provide obstetrical and gynecological care in an area Hospital.

G. Has a minimum of two beds or two birthing rooms for patients in labor and during delivery.

H. Provides, in the delivery and recovery room, full-time skilled nursing services under the direction of Registered Nurses (R.N.s).

I. Has diagnostic X-ray and laboratory equipment necessary to perform tests on the mother and the Newborn.

J. Has equipment and supplies necessary to perform surgery, including episiotomy and repair of perineal tear, and to administer a local anesthetic.

K. Has equipment and trained personnel necessary to deal with medical emergencies; is able to provide immediate support measures to sustain life for complications arising during labor or for Newborns with abnormalities that impair function or threaten life.

L. Has an admission policy for accepting only patients with low-risk Pregnancies.

M. Has a written agreement with an area Hospital for immediate transfer in case of emergency; displays written procedures for such a transfer and ensures that the staff is aware of these procedures.

N. Provides an ongoing quality assurance program with reviews by M.D.s or D.O.s other than those who own, direct, or are employed by the Birthing Center.

O. Keeps written and comprehensive medical records on each patient admitted to, and each infant born at, the Birthing Center.

BUSINESS ASSOCIATE

The term "Business Associate" means a person or entity who does the following:

A. Performs or assists in performing a Plan function or activity involving the use and disclosure of PHI (including claims processing or administration, data analysis, underwriting, etc.).

B. Provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

CALENDAR YEAR

The term "Calendar Year" means a period of time beginning with January 1 and ending on the following December 31.

CERTIFIED REGISTERED NURSE ANESTHETIST

The term "Certified Registered Nurse Anesthetist" means an individual who has received specialized nurse-anesthetist training, is authorized to use the designation of "C.R.N.A.," and is duly licensed by the state or regulatory agency responsible for licensing in the state in which the individual performs nurse-anesthetist services.

CHANGE IN STATUS

The term "Change in Status" as set forth by HIPAA means any of the following:

A. An event that changes the Employee's legal marital status, including marriage, death of the Employee's spouse, divorce, legal separation (if recognized by the state in which the individuals reside), and annulment.

B. An event that changes the number of an Employee's dependents, including birth, adoption, placement for adoption, and death of a dependent.

C. An event affecting the employment status of the Employee, the Employee's spouse, or the Employee's dependent; including termination or commencement of employment, a strike or lockout, commencement of or return from an unpaid leave of absence, a change in work site, and any other change in employment status that affects an individual's eligibility for benefits.

D. An event that causes an Employee's dependent to satisfy or cease to satisfy the requirement(s) for coverage owing to the attainment of a specified age, student status, or any similar circumstance.

E. A change in the place of residence of the Employee, the Employee's spouse, or the Employee's dependent.

CLAIM ADMINISTRATOR

The term "Claim Administrator" means the person or firm, if any, retained by the Plan Administrator to handle the processing, payment, and settlement of benefit claims and other duties specified in a written administration agreement. If there is no Claim Administrator (for any reason, including circumstances caused by the termination or expiration of the Administration Agreement with the initial Claim Administrator), or if the term is used in connection with a duty not expressly assumed by the Claim Administrator in a signed writing, the term shall mean the Plan Administrator. In no event will the use of the term Claim Administrator throughout this Plan document confer responsibilities that have not explicitly been delegated to the Claim Administrator in writing in an Administration Agreement or other written agreement between the Claim Administrator and the Plan Administrator.

CLOSE RELATIVE

The term "Close Relative" means the spouse, parent, brother, sister, child, or in-laws of a Covered Person.

COBRA

The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (see Section 4980B of the Code and Sections 601 et seq. of the Employee Retirement Income Security Act of 1974 [ERISA], as amended). See Consolidated Omnibus Budget Reconciliation Act of 1985.

CODE

The term "Code" means the Internal Revenue Code of 1986, as amended.

COINSURANCE

The term "Coinsurance" means a Covered Person's share of the cost of an eligible Covered Expense. Coinsurance is expressed as a percentage (for example, 20%) and typically applies after the Deductible (if any) has been satisfied.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

The term "Consolidated Omnibus Budget Reconciliation Act of 1985" means federal legislation that gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances. In the context of a governmental employer, this term means the parallel continuation coverage provisions of the Public Health Service Act. See COBRA.

CONVALESCENT NURSING FACILITY

The term "Convalescent Nursing Facility" means an institution, or a distinct part of an institution, that is operated pursuant to law and meets all of the following conditions:

A. It is licensed to provide, and is engaged in providing, for persons convalescing from Injury or Illness on an Inpatient basis, professional nursing services rendered by a Registered Nurse, or by a Licensed Practical Nurse under the direction of a Registered Nurse, and physical restoration services to assist patients to reach a degree of bodily functioning to permit self-care in essential daily living activities.

B. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse.

C. It maintains a complete medical record on each patient.

D. It has an effective utilization review plan.

E. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, persons with developmental or learning disabilities, custodial or educational care, or care of mental disorders.

This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, convalescent nursing home, or any other similar nomenclature.

COSMETIC PROCEDURE

The term "Cosmetic Procedure" means any procedure that is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness, Injury, or disease.

COVERED EXPENSES

The term "Covered Expenses" means expenses incurred by a Covered Person for any Medically Necessary treatments, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan. Covered Expenses are incurred on the date that any Medically Necessary treatments, services, or supplies are provided to a Covered Person.

COVERED PERSON

The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan. This term includes Participants and their eligible Dependents.

CUSTODIAL CARE

The term "Custodial Care" means that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

DEDUCTIBLE

The term "Deductible" means a specified dollar amount of Covered Expenses that may need to be, as detailed in the Schedule of Benefits, incurred during a year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and in this Plan.

DEPENDENT

The term "Dependent" means the following:

A. The Participant's legal spouse who has met all of the requirements of a valid marriage contract in the state of marriage of the parties. A Participant's domestic partner (whether of the same or opposite gender) is not considered to be the Participant's legal spouse for Plan eligibility purposes.

B. A child who meets all of the following conditions:

1. May be identified in one of the following categories:

a. The Participant's natural child, the Participant's stepchild, the Participant's legally adopted child, or a child who is being placed for adoption with the Participant.

b. A child who is under the legal guardianship of the Participant, is unmarried, and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of current legal guardianship status must be furnished to the satisfaction of the Plan Administrator.

c. A child to whom the Participant is obligated to provide medical care coverage under an order or judgment of a court of competent jurisdiction and could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code.

2. Is less than 26 years of age. Coverage will continue through the end of the Calendar Year in which the child's 26th birthday occurs. The age requirement above is waived for any child who is developmentally disabled or who has a physical handicap(s) before age 19 who is incapable of self-sustaining employment, and who could be considered a "dependent" of the Participant for tax exemption purposes under Section 152 of the Code. Proof of incapacity must be furnished to the satisfaction of the Claim Administrator prior to the end of the Calendar Year in which the child's 26th birthday occurs and upon request (i.e., the Plan Administrator may request additional proof from time to time).

C. A child for whom the Participant is obligated to provide medical coverage under a National Medical Support Notice, notwithstanding the above.

The Participant may be asked to certify the status of the persons for whom the Participant is claiming Dependent status, and benefits shall be terminated and the Participant may be asked to reimburse the Plan if it is discovered that he/she has provided false information.

In the event of a Retiree's death, any surviving Dependents of the Retiree may also be eligible to be covered under the Plan as specified in the Retiree Coverage section. Such surviving Dependents will be subject to the terms of this definition, except when the terms are deemed by the Claim Administrator to no longer be applicable as a result of the Participant's death.

For purposes of providing coverage to a Dependent pursuant to an Employee or Retiree electing to enroll in the Employer's Medicare Supplemental coverage, the term "Participant," as used in this definition, means the Employee or Retiree who is eligible for and enrolled in the Medicare Supplemental coverage offered by the Employer but who is not enrolled in this Plan.

The term "Dependent" excludes these situations:

A. A spouse or former spouse who is legally separated or divorced from the Participant, pursuant to a valid separation or divorce in the state granting the separation or divorce.

B. Any person who would otherwise qualify as a Dependent, but who is not properly enrolled in the Plan.

DEPENDENT COVERAGE

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent or, if allowable under the Plan, for Routine preventive care for a Dependent.

DURABLE MEDICAL EQUIPMENT

The term "Durable Medical Equipment" means equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful for a person in the absence of Illness or Injury.

Modifications to houses or vehicles, including, but not limited to, platform lifts, stair lifts, stairway elevators, wheelchair lifts or ramps, and ceiling lifts are not considered Durable Medical Equipment and are not covered under the Plan.

EMPLOYEE

The term "Employee" means a common-law employee of the Employer. An independent contractor is not an Employee. Further, a leased employee within the meaning of Code Section 414(n) is not an Employee. If an independent contractor or a leased employee is subsequently characterized as a common-law employee of the Employer, that person shall not be eligible to participate in the Plan for any time period before the date on which the determination is made that that person is a common-law employee of the Employer.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

The term "Employee Retirement Income Security Act of 1974" means a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. See ERISA.

EMPLOYER

The term "Employer" means **OAKLAND COUNTY**.

ERISA

The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended, Section 3(1), 29 U.S.C. §1002(1). See Employee Retirement Income Security Act of 1974.

ESSENTIAL HEALTH BENEFIT

The term "Essential Health Benefit" has the meaning set forth by Health Care Reform. A list of Essential Health Benefits can be viewed by logging on to the Claim Administrator's Website address printed on the back of the Covered Person's identification card.

EXPERIMENTAL; INVESTIGATIONAL

The term "Experimental" or "Investigational" means a drug, device, medical treatment, or procedure (other than a covered Off-Label Use) that meets any of the following criteria:

A. The U.S. Food and Drug Administration (FDA) must approve the lawful marketing of the drug, device, treatment, or procedure, and the FDA gave no such approval when initially receiving the drug, device, treatment, or procedure.

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

C. The drug, device, medical treatment, or procedure is shown by Reliable Evidence to be any of the following:

   1. The subject of ongoing Phase I or Phase II clinical trials.

   2. The research, experimental, study, or investigational arm of ongoing Phase III clinical trials.

   3. Otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

D. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its

efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

Off-Label Use shall not be considered Experimental or Investigational where all of the following requirements are satisfied:

A. The drug, device, medical treatment, or procedure is otherwise a Covered Expense under the Plan.

B. The drug, device, medical treatment, or procedure has been approved by the FDA.

C. The Off-Label Use of the drug, device, medical treatment, or procedure has been recognized for treatment of the condition for which it is prescribed by one of the following:

1. Micromedex® DRUGDEX® (Micromedex® and DRUGDEX® are registered trademarks of Truven Health Analytics).

2. The American Hospital Formulary Service Drug Information.

3. Formal clinical studies, the results of which have been published in at least two peer-reviewed professional journals published in the United States or Great Britain.

4. Standard reference compendia or substantially accepted peer-reviewed medical literature.

FAMILY

The term "Family" means a Participant and any Dependent(s).

FAMILY AND MEDICAL LEAVE ACT OF 1993

The term "Family and Medical Leave Act of 1993" means a federal law that provides certain employees with unpaid, job-protected leave each year, the duration of which is pre-determined by the federal government. It also requires that their group health benefits be maintained during the leave. See FMLA.

FMLA

The term "FMLA" means the Family and Medical Leave Act of 1993, Public Law 103-3 (February 5, 1993), 107 Stat. 6 (29 U.S.C. 2601 et seq.). See Family and Medical Leave Act of 1993.

FULL-TIME EMPLOYMENT

The term "Full-Time Employment" means a basis by which a Participant is employed and is compensated for services by the Employer for at least the number of hours per week stated in the eligibility requirements of the Schedule for Eligibility and Participation. The work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel. A full-time Employee who is absent from work because of a health condition is considered to work in Full-Time Employment for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation. Additionally, a full-time Employee who is absent from work because the Employer has granted a Leave of Absence Without Pay (as this leave is further defined in the Employer's policies) is generally considered to work in Full-Time Employment for the first ten days of one Employer-sanctioned leave per Calendar Year for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

HEALTH CARE REFORM

The term "Health Care Reform" refers to the collective body of legislation that originated with the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) and grew to include any later laws that amend either of those Acts directly or indirectly, in whole or in part.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The term "Health Insurance Portability and Accountability Act of 1996" means a federal law that limits the use of pre-existing condition exclusions, waiting periods, and health status exclusions; eliminates certain discriminatory exclusions, such as for self-inflicted injuries; and promulgates administrative simplification provisions. See HIPAA.

HIPAA

The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended (Public Law 104-191). See Health Insurance Portability and Accountability Act of 1996.

HOME HEALTH CARE AGENCY

The term "Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. This type of provider must meet all of the following conditions:

A. It is primarily engaged in providing skilled nursing services and other therapeutic services and is duly licensed, if such licensing is required, by the appropriate licensing authority.

B. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at

least one Registered Nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse.

C. It maintains a complete medical record on each individual.

D. It has a full-time administrator.

HOSPICE

The term "Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPICE BENEFIT PERIOD

The term "Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. This time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill and the Covered Person is accepted into a Hospice program. The earliest that the period shall end is six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill. However, the Plan Administrator may require additional proof before such a new Hospice Benefit Period can begin.

HOSPITAL

The term "Hospital" means an institution that meets all of the following conditions:

A. It is primarily engaged in providing medical care and treatment to Ill and Injured persons on an Inpatient basis at the patient's expense.

B. It is constituted, licensed, and operated in accordance with the laws that pertain to hospitals of the jurisdiction in which it is located.

C. It maintains on its premises all of the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury, unless it is a Behavioral Care, Addictions Treatment, or rehabilitation hospital.

D. Treatment is provided for compensation by or under the supervision of Physicians, with continuous 24-hour nursing services by Registered Nurses.

E. It qualifies as a hospital, a Behavioral Care hospital, or a tuberculosis hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Osteopathic Association (AOA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or DNV Healthcare, Inc. (DNV). If the Centers for Medicare and Medicaid Services has

designated the facility as a critical access hospital, the JCAHO, AOA, CARF, or DNV accreditation requirement will be waived.

F. It is not, other than incidentally, a nursing home or a place for rest, the aged, drug addicts, or alcoholics.

ILLNESS

The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, Functional Nervous Disorder, or Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All disorders existing simultaneously that are caused by the same or related causes shall be considered one Illness.

INJURY

The term "Injury" means a localized, abnormal condition of the body, internal or external, traumatically induced.

IN-NETWORK PROVIDERS

The term "In-Network Providers" means a group of Physicians, Hospitals, and other medical providers that have agreed to provide health care at discounted fees in accordance with the Utilization of In-Network Providers section.

INPATIENT

The term "Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

The term "Intensive Care Unit" means a section, ward, or wing within the Hospital that is separated from other facilities and meets the following criteria:

A. Is operated exclusively for the purpose of providing professional medical treatment for patients who have a critical Illness or Injury.

B. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use.

C. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

LICENSED PRACTICAL NURSE

The term "Licensed Practical Nurse" means an individual who is trained in basic nursing techniques and direct patient care, practices under the supervision of a Registered Nurse, is

authorized to use the designation of "L.P.N.," and is duly licensed by the state or the regulatory agency in the state in which the individual performs these nursing services.

LIFETIME

The term "Lifetime" means the time a person is actually a Covered Person in this Plan, including any amendment or restatement of this Plan. The term "Lifetime" is not intended to suggest benefits before the effective date of an individual or after the termination of an individual or of the Plan.

MEDICAL EMERGENCY

The term "Medical Emergency" refers to any Injury or Illness of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that this Illness or Injury is of such a nature that failure to obtain immediate medical care could result in one of the following problems:

A. Serious jeopardy to the Covered Person's health.

B. Serious impairment to bodily functions.

C. Serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

The term "Medically Necessary" means a service, medicine, or supply that satisfies the requirements described in this section.

A. *Requirements.* A service, medicine, or supply is Medically Necessary if it satisfies all of the following requirements:

1. It must be Usual and Customary for the diagnosis and treatment of an Illness or Injury.

2. It must be legal.

3. It must be ordered by a Physician or Physician's Assistant. However, the fact that a service, medicine, or supply is ordered by a Physician or Physician's Assistant does not mean that the service, medicine, or supply is Medically Necessary.

4. It must be commonly and customarily recognized throughout the Physician's profession as appropriate in treating the diagnosed Illness or Injury.

5. It must be provided at an appropriate level of care to treat the diagnosed Illness or Injury.

B. *Exclusions*. Services, medicines, or supplies that are not Medically Necessary shall include, but shall not be limited to, the following items:

1. Procedures that are of unproven value or of questionable current usefulness.

2. Procedures that tend to be repetitive when performed in combination with other procedures.

3. Diagnostic procedures that are unlikely to provide a Physician with additional information when they are used repeatedly.

4. Procedures that are not ordered by a Physician or Physician's Assistant or that are not documented in the patient's medical records.

5. Services, medicines, and supplies furnished for the personal comfort or convenience of the patient.

A determination that a service, medicine, or supply is not Medically Necessary may apply to all or a portion of the service, medicine, or supply. The Claim Administrator, in its sole discretion, shall make the final determination as to whether a service, medicine, or supply is Medically Necessary.

MEDICARE

The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and that includes parts A and B of Subchapter XVIII of the Social Security Act as amended from time to time.

MENTAL ILLNESS OR DISORDER AND FUNCTIONAL NERVOUS DISORDER

The term "Mental Illness or Disorder and Functional Nervous Disorder" means mental, psychoneurotic, or personality disorders.

NEWBORN

The term "Newborn" means an infant from the date of the infant's birth until the initial Hospital discharge or until the infant is 14 days old, whichever occurs first.

NURSE PRACTITIONER; NURSE CLINICIAN; CLINICAL NURSE SPECIALIST

The terms "Nurse Practitioner," "Nurse Clinician," and "Clinical Nurse Specialist" mean a Registered Nurse who has been trained in an accredited program and is certified by an appropriate board to perform certain of a Physician's duties, who is acting within the scope of his or her license, and who is under the supervision of a licensed Physician. The term "Nurse Practitioner" shall include Nurse Clinicians and Clinical Nurse Specialists whenever that term is used in the Plan.

Services provided by a Nurse Practitioner, Nurse Clinician, or Clinical Nurse Specialist will be considered to be Covered Expenses under the Plan, based on all Plan provisions, limitations, and requirements.

NURSE-MIDWIFE

The term "Nurse-Midwife" means a person who is certified or licensed and insured in accordance with the laws of the state in which care and delivery occur, and who is acting within the scope of his or her license while providing services.

OBESITY

The term "Obesity" means the physical state in which excess fat is stored at various sites in the body with an increase in body weight beyond the limitations of skeletal and physical requirements as evidenced by a body mass index (BMI) of 30 or greater.

OBRA 1993

The term "OBRA 1993" means the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66 (August 10, 1993). See Omnibus Budget Reconciliation Act of 1993.

OCCUPATIONAL THERAPY

The term "Occupational Therapy" means the use of purposeful activity with individuals who are limited by physical Injury or Illness to assist in their rehabilitation and to restore normal function after an Injury or Illness. The practice encompasses evaluation, treatment, and consultation. Psychosocial dysfunction, developmental or learning disabilities, socioeconomic differences, and the aging process are excluded from this definition.

OFF-LABEL USE

The term "Off-Label Use" means the use of a drug, device, medical treatment, or procedure for a purpose other than that for which it was approved by the U.S. Food and Drug Administration (FDA).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993

The term "Omnibus Budget Reconciliation Act of 1993" means a federal law that adds a provision to COBRA's tax code rules regarding pediatric vaccine coverage. See OBRA 1993.

ORTHOPTICS; VISION THERAPY

The terms "Orthoptics" and "Vision Therapy" mean the science of correcting defects in a person's simultaneous use of both eyes (binocular vision) through administration of vision therapy aids and/or eye muscle exercises.

ORTHOTIC OR PROSTHETIC APPLIANCE

The term "Orthotic or Prosthetic Appliance" means an internal or external device or structure intended to correct any defect in form or function of the human body.

OUT-OF-NETWORK PROVIDERS

The term "Out-of-Network Providers" means a group of Physicians, Hospitals, and other medical providers that do not participate within a plan's contracted network and do not provide health care at discounted fees.

OUTPATIENT

The term "Outpatient" refers to the classification of a Covered Person when that Covered Person receives medical care, treatment, services, or supplies at a clinic, a Physician's office, a Telemedicine e-visit, a Hospital (if not a registered bed patient at that Hospital), an Outpatient Behavioral Care Facility, or an Outpatient Addictions Treatment Facility.

OUTPATIENT ADDICTIONS TREATMENT FACILITY

The term "Outpatient Addictions Treatment Facility" means an institution that meets the following criteria:

A. Provides a program for diagnosis, evaluation, and effective treatment of alcoholism, drug abuse, or substance abuse.

B. Provides detoxification services necessary to its effective treatment program.

C. Provides infirmary-level medical services or arrangements at a Hospital in the area for any other medical services that may be required.

D. Is at all times supervised by a staff of Physicians.

E. Provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse.

F. Meets licensing standards.

OUTPATIENT BEHAVIORAL CARE FACILITY

The term "Outpatient Behavioral Care Facility" means an administratively distinct governmental, public, private, or independent unit, or a part of such unit, that provides Outpatient Behavioral Care services, and that provides for a psychiatrist who has regularly scheduled hours in the facility and assumes the overall responsibility for coordinating the care of all patients.

PART-TIME ELIGIBLE POSITION

The term "Part-Time Eligible Position" means a basis by which a Participant is employed in a position that is considered by the Employer to be eligible for Plan coverage and is compensated for services by the Employer for at least the number of hours per Calendar Year stated in the Employer's policies. The work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Participant to travel. An Employee who is absent from work because of a health condition is considered to be working in

a Part-Time Eligible Position for purposes of satisfying any waiting period set forth in the eligibility requirements of the Schedule for Eligibility and Participation.

PARTICIPANT

The term "Participant" means a person who is or was directly employed and compensated for services by the Employer, who meets the other eligibility requirements, and who is properly enrolled in the Plan. The term includes a Retiree who meets the other eligibility requirements and who is properly enrolled in the Plan, if the Plan's eligibility requirements permit Retiree participation.

PARTICIPANT COVERAGE

The term "Participant Coverage" means coverage included under this Plan providing benefits payable as a consequence of an Injury or Illness of a Participant or, if allowable under the Plan, for Routine preventive care for a Participant.

PHI

See Protected Health Information.

PHYSICAL THERAPY

The term "Physical Therapy" means the treatment of disorders with physical agents and methods under the supervision of a licensed physical therapist, including, but not limited to, massage, manipulation, therapeutic exercises, cold, heat (including shortwave, microwave, and ultrasonic diathermy), hydrotherapy, electric stimulation, and light to assist in rehabilitating individuals and in restoring normal function after an Illness or Injury. Also called physiotherapy.

PHYSICIAN

The term "Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, optometrist, perfusionist, board certified behavioral analyst, certified consulting Psychologist, or limited licensed psychologist to the extent that he/she, within the scope of his/her license or certification, is permitted to perform services provided in this Plan. The term Physician may include a Physician's Assistant or Nurse Practitioner, but shall not include the Covered Person or any Close Relative of the Covered Person.

PHYSICIAN'S ASSISTANT

The term "Physician's Assistant" means one who has been trained in an accredited program and is certified by an appropriate board to perform certain of a Physician's duties, who is acting within the scope of his or her license, and who is under the supervision of a licensed Physician.

Services provided by a Physician's Assistant will be considered to be Covered Expenses under the Plan, based on all Plan provisions, limitations, and requirements.

PLAN

The term "Plan" means the PPO1 Health Benefit Plan for Oakland County, as periodically amended.

PLAN ADMINISTRATOR

The term "Plan Administrator" means **OAKLAND COUNTY**, who is responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

PLAN SPONSOR

The term "Plan Sponsor" means **OAKLAND COUNTY**.

PLAN YEAR

The term "Plan Year" means the 12-month period that begins on January 1 and ends on the following December 31. This time period is used for purposes of determining annual benefit-based accumulators (e.g., Deductibles and out-of-pocket limits), Form 5500 reporting (if required), compliance with the Patient Protection and Affordable Care Act (PPACA), as amended, and compliance with other laws impacting the Plan.

PREGNANCY

The term "Pregnancy" means the physical state that results in childbirth, abortion, or miscarriage and any medical complications arising out of or resulting from that state.

PROTECTED HEALTH INFORMATION

The term "Protected Health Information" means information that is created or received by the Plan or a Business Associate and relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care to a Covered Person, or the past, present, or future payment for the provision of health care to a Covered Person. Also, the information identifies the Covered Person or there is a reasonable basis to believe the information can be used to identify the Covered Person (whether living or deceased). The identifiers listed in 45 CFR 164.514(b)(2)(i) will enable identification.

PSYCHOLOGIST

The term "Psychologist" means an individual holding the degree of Ph.D., Psy.D., or Ed.D. and acting within the scope of his or her applicable licenses.

REGISTERED NURSE

The term "Registered Nurse" means an individual who has received specialized nursing training, is authorized to use the designation of "R.N.," and is duly licensed by the state or regulatory agency responsible for licensing in the state in which the individual performs nursing services.

RETIRED EMPLOYEE; RETIREE

The term "Retired Employee" or "Retiree" means a person is or was eligible for benefits under this Plan as a Retiree as defined by the Employer. For details on Retiree coverage and the rules for such coverage, including, but not limited to, the specific hire dates applicable to each bargaining unit, refer to the Employer's written policies.

ROOM AND BOARD

The term "Room and Board" refers to all charges, by whatever name called, that are made by a Hospital, Hospice, or Convalescent Nursing Facility as a condition of occupancy. Charges do not include the professional service of Physicians or intensive nursing care by whatever name called.

ROUTINE

The term "Routine" means services provided to individuals for the purpose of promoting health and preventing Illness or Injury, including evaluation and management of individuals when these services are performed in the absence of patient complaints.

SEMI-PRIVATE

The term "Semi-Private" refers to a class of accommodations in a Hospital or Convalescent Nursing Facility in which at least two patients' beds are available per room.

SPECIAL ENROLLMENT PERIOD

The term "Special Enrollment Period" means the period for an individual with special enrollment rights to make enrollment elections under the Plan. The circumstances under which an individual has special enrollment rights are described in the Participant Enrollment and Dependent Enrollment sections and are in general prescribed by HIPAA and federal regulations issued pursuant to HIPAA.

SPEECH THERAPY

The term "Speech Therapy" means the treatment of disorders of articulation, language, and voice under the supervision of a licensed speech therapist, including, but not limited to, evaluation of motor-speech skills; expressive and receptive language skills; writing and reading skills; cognitive functioning; social interaction skills; and the development of speech, listening, and conversation skills.

SUMMARY HEALTH INFORMATION

The term "Summary Health Information" means information that may be individually identifiable health information. It summarizes the claims history, claims expenses, or types of claims experienced by individuals for whom Plan Sponsor has provided health benefits under the Plan. The information described in 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information may be aggregated to the level of five-digit ZIP codes.

TELEMEDICINE

The term "Telemedicine" means medical care provided through electronic or telephonic communications. Telemedicine care is typically rendered as an alternative to a traditional office visit and provides "on demand" medical care as well as remote evaluations/monitoring by phone, computer, or mobile device.

TOTAL DISABILITY; TOTALLY DISABLED

The term "Total Disability" or "Totally Disabled" (as this term is used throughout this Plan document) means a physical state of a Covered Person resulting from an Illness or Injury that wholly prevents either of the following activities:

A. A Participant engaging in any and every business or occupation and performing any and all work for compensation or profit.

B. A Dependent performing the normal functions and activities of a person of like age and gender in good health.

USUAL AND CUSTOMARY

The term "Usual and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, and supplies, medications, or equipment that do not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or expertise.

UTILIZATION REVIEW DEPARTMENT

The term "Utilization Review Department" means the department of the Claim Administrator providing Hospital admission certification and other utilization review services in connection with the Plan.

RULES OF CONSTRUCTION

This Plan shall be construed in accordance with the Code and, where not pre-empted, the laws of the state of Michigan.

The use of the singular includes the plural where applicable and vice versa. The headings do not limit or extend the provisions of the Plan. Capitalized terms, except where capitalized solely for grammar, have the meaning provided in the Plan. Errors cannot cause the Plan to provide a benefit that a Covered Person is not otherwise entitled to under the Plan. If a provision is unenforceable in a legal proceeding, the provision shall be severed solely for purposes of that proceeding and the remaining provisions of the Plan shall remain in full force.

Oakland County has caused this amended and restated Plan to be effective as of 12:01 a.m. local time, January 1, 2019.