Anderson County Government

ASO Request for Proposal Questions and Answers

1- Do you have any current plan design info for Anderson County?
   - See attached

2- Would we be able to get an extension on this group? Reason being our GM is traveling a ton and we need more time to coordinate the wet signatures needed with a notary.
   - No – an extension will not be granted at this time.

3- Who is the incumbent PBM and Medical Carrier / TPA for Anderson County, TN Government?
   - PBM – Ventegra
   - Medical TPA - MedBen

4- Can you please confirm the number of employees and the number of members for Anderson County, TN Government RFP?
   - Number of participating employees: 318
   - Number of participating members (including dependents): 711

5- Can you please provide the current SPDs / SBCs for Anderson County, TN Government?
   - See attached

6- Is Anderson County, TN Government receiving an admin credit or rebates on pharmacy?
   - Rebates

7- Is the group's Rx carved in or carved out?
   - Carved Out

8- If the Rx is carved in, is the group's Rx with a carrier or a TPA? What is the name of the carrier or TPA?
   - Not applicable, since RX is carved out

9- If the Rx is carved out, which PBM is currently the incumbent?
   - Ventegra

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-877-267-2323 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,000 per individual & $2,000 per family for in-network; $2,000 per individual & $4,000 per family for out-of-network. There is a separate deductible of $125 per individual & $250 per family under the prescription drug program.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care/services and items in which a copayment applies when provided in-network, other than emergency room services, are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 per individual & $6,000 per family for in-network; $9,000 per individual & $18,000 per family for out-of-network. There is a separate out-of-pocket limit of $1,500 per individual & $3,500 per family under the prescription drug program.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, charges this plan doesn't cover, and precertification penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com or call 1-800-922-4362 (PHCS with Multiplan Wrap) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copayment; deductible does not apply	50% coinsurance	Includes Telehealth visits. If office visit charged, all office-based injections, including allergy injections, and the administration, allergy serum/venom & diagnostic/laboratory services are covered at no charge after the applicable copayment. In-network medical supplies & office-based surgery pay at 20% coinsurance after the deductible whether or not an office visit is charged. If no office visit charged; 20% coinsurance after the deductible for in-network diagnostic/laboratory services & injections/administration of injections other than allergy. In-network allergy injections, their administration and the serum/venom are subject to the applicable office visit copayment.
	Specialist visit	$40 copayment; deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	Routine hearing & eye exams through age 21; Retinopathy vision screening for diabetics - 1 exam per year, subject to 20% coinsurance after the deductible in-network; Cologuard testing - 1 every 3 years; nutritional counseling – 12 visits per year & only for members with certain illnesses, as outlined in the plan document; primary care tobacco cessation counseling – 8 visits per year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition For more information about prescription drug coverage that is available through Ventegra, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs	$10 copayment for a 30 day supply under retail; $20 copayment for 90 day supply under mail order	Not covered except through retail/mail order	No charge for certain preventive care/screening medications and products. See plan document for listing. The separate prescription deductible must be met before the copayment/coinsurance listed to the left applies. Mail order services are limited to maintenance drugs only. Non-maintenance drugs are not covered through the mail order program. Prescriptions filled at Walgreens Pharmacy are not covered.
	Preferred brand drugs	$30 copayment for maintenance drugs; all others, 30% coinsurance up to $125 for a 30 day supply under retail; $60 copayment for 90 day supply under mail order	Not covered except through retail/mail order	
	Non-preferred brand drugs	$40 copayment for maintenance drugs; all others, 30% coinsurance + $30 up to $175 for a 30 day supply under retail; $80 copayment for 90 day supply under mail order	Not covered except through retail/mail order	
	Specialty drugs	30% coinsurance + $30 up to $175 for a 30 day supply under retail program only	50% coinsurance	Provider administered specialty drugs are covered under the medical provisions at no charge in-network. Retail/mail order limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$500 copayment, then 20% coinsurance after the deductible	Paid at in-network level	None.
	Emergency medical transportation	20% coinsurance	Paid at in-network level	Includes air ambulance.
	Urgent care	$50 copayment; deductible does not apply	50% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment for office visits; deductible does not apply; 20% coinsurance for other outpatient services	50% coinsurance	Office visits include individual & group counseling services.
	Inpatient services	20% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
If you are pregnant	Office visits	Paid the same as other illness	50% coinsurance	Dependent child maternity, including complications are not covered.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Pre-certification required after 48 hours following vaginal delivery or 96 hours following c-section. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Therapy services provided under home health care are subject to the therapy limitations listed below. Precertification required for skilled nursing. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Rehabilitation services	20% coinsurance	50% coinsurance	Physical, occupational & speech therapy limited to 25 visits each per year, unless additional visits are medically necessary. Cardiac rehabilitation & pulmonary therapy limited to 36 visits each per year, unless additional visits are medically necessary. Spinal pain injections limited to 3 per site per

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	20% coinsurance	50% coinsurance	12 months, unless medically necessary with approval. Autism services, including ABA therapy for children under age 12. Precertification required for proton beam therapy. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 60 days per year. Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Durable medical equipment	20% coinsurance	50% coinsurance	None.
	Hospice services	20% coinsurance	50% coinsurance	Precertification required if inpatient. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500. Bereavement counseling is covered at no charge in-network, *through 10/1/19.*
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	If included in the preventive care recommendations covered through age 21. Retinopathy vision screenings for diabetics, limited to 1 per year for all ages.
	Children's glasses	Not covered	Not covered	Separate vision coverage available.
	Children's dental check-up	Not covered	Not covered	Separate dental coverage available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture,
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances,
- Cosmetic Surgery, unless specifically listed in plan as covered,
- Dental Care, except for accidental dental care started within 3 months of the accident for up to 12 months after,
- Infertility Treatment, not including testing leading up to diagnosis and corrections to correct the defect preventing conception,
- Long Term Care,
- Non-emergency care when traveling outside the U.S.,
- Private Duty Nursing,
- Routine eye care (Adult), except for diabetic exams, limited to 1 per year,
- Weight Loss Programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery,	• Chiropractic Care, $50 copayment for office evaluation/deductible does not apply; other services 20% coinsurance after the deductible. 50% coinsurance for out-of-network. Spinal manipulations limited to 25 visits per year, and	• Dialysis Services (outpatient) are limited to 125% of the Medicare allowable rate; 20% coinsurance. In-network benefits apply out-of-network, • Hearing Aids, limited to 1 per ear every 3 years, and • Routine Foot Care, *effective 10/2/19*.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/. Contact: Tennessee Department of Commerce & Insurance, 500 James Robertson Parkway, Davy Crockett Tower, 4th floor, Nashville, TN 37243-0565 or by phone at 1-615-741-2241, online at http://www.tn.gov/commerce/section/consumer-services.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-862-6704.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,000
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,200
Copayments	$20
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$600
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,000
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,800**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,000
Specialist *copayment*	$40
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 per individual & $4,000 per family for in-network; $3,000 per individual & $6,000 per family for out-of-network. There is a separate deductible of $250 per individual & $500 per family under the prescription program.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care/services and items in which a copayment applies when provided in-network are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,000 per individual & $8,000 per family for in-network; $18,000 per individual & $36,000 per family for out-of-network. There is a separate prescription out-of-pocket limit of $2,000 per individual & $4,000 per family under the prescription drug program.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, charges this plan doesn't cover, and precertification penalties.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.multiplan.com or call 1-800-922-4362 (PHCS with Multiplan Wrap) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copayment; deductible does not apply	50% coinsurance	Includes Telehealth visits. If office visit charged, all office-based injections, including allergy injections, and the administration, allergy serum/venom & diagnostic/laboratory services are covered at no charge after the applicable copayment. In-network medical supplies & office-based surgery pay at 30% coinsurance after the deductible whether or not an office visit is charged. If no office visit charged; 30% coinsurance after the deductible for in-network diagnostic/laboratory services & injections/administration of injections other than allergy. In-network allergy injections, their administration and the serum/venom are subject to the applicable office visit copayment.
	Specialist visit	$50 copayment; deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	Routine hearing & eye exams through age 21; Retinopathy vision screening for diabetics - 1 exam per year, subject to 30% coinsurance after the deductible in-network; Cologuard testing - 1 every 3 years; nutritional counseling – 12 visits per year & only for members with certain illnesses, as outlined in the plan document; primary care tobacco cessation counseling – 8 visits per year. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition For more information about prescription drug coverage that is available through Ventegra, contact MedBen's Customer Service Department at 1-800-686-8425.	Generic drugs	$10 copayment for a 30 day supply under retail; $20 copayment for 90 day supply under mail order	Not covered except through retail/mail order	No charge for certain preventive care/screening medications and products. See plan document for listing. The separate prescription deductible must be met before the copayment/coinsurance listed to the left applies. Mail order services are limited to maintenance drugs only. Non-maintenance drugs are not covered through the mail order program. Prescriptions filled at Walgreens Pharmacy are not covered.
	Preferred brand drugs	$30 copayment for maintenance drugs; all others, 30% coinsurance up to $125 for a 30 day supply under retail; $60 copayment for 90 day supply under mail order	Not covered except through retail/mail order	
	Non-preferred brand drugs	$40 copayment for maintenance drugs; all others, 30% coinsurance + $30 up to $175 for a 30 day supply under retail; $80 copayment for 90 day supply under mail order	Not covered except through retail/mail order	
	Specialty drugs	30% coinsurance + $30 up to $175 for a 30 day supply under retail program only	50% coinsurance	Provider administered specialty drugs are covered under the medical provisions at no charge in-network. Retail/mail order limited to a 30 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	Paid at in-network level	None.
	Emergency medical transportation	30% coinsurance	Paid at in-network level	Includes air ambulance.
	Urgent care	$75 copayment; deductible does not apply	50% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copayment for office visits; deductible does not apply; 30% coinsurance for other outpatient services	50% coinsurance	Office visits include individual & group counseling services.
	Inpatient services	30% coinsurance	50% coinsurance	Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
If you are pregnant	Office visits	Paid the same as other illness	50% coinsurance	Dependent child maternity, including complications are not covered.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	None.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Pre-certification required after 48 hours following vaginal delivery or 96 hours following c-section. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Therapy services provided under home health care are subject to the therapy limitations listed below. Precertification required for skilled nursing. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Rehabilitation services	30% coinsurance	50% coinsurance	Physical, occupational & speech therapy limited to 25 visits each per year, unless additional visits are medically necessary. Cardiac rehabilitation & pulmonary therapy limited to 36 visits each per year, unless

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	30% coinsurance	50% coinsurance	additional visit are medically necessary. Spinal pain injections limited to 3 per site per 12 months, unless medically necessary with approval. Autism services, including ABA therapy for children under age 12. Precertification required for proton beam therapy. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per year. Precertification required. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500.
	Durable medical equipment	30% coinsurance	50% coinsurance	None.
	Hospice services	30% coinsurance	50% coinsurance	Precertification required if inpatient. Failure to pre-certify will result in a 20% reduction in benefits up to a maximum of $500. Bereavement counseling is covered at no charge in-network, *through 10/1/19*.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	If included in the preventive care recommendations covered through age 21. Retinopathy vision screenings for diabetics, limited to 1 per year for all ages.
	Children's glasses	Not covered	Not covered	Separate vision coverage available.
	Children's dental check-up	Not covered	Not covered	Separate dental coverage available.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture,
- Benefits paid as a result of injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances,
- Cosmetic Surgery, unless specifically listed in plan as covered,
- Dental Care, except for accidental dental care started within 3 months of the accident for up to 12 months after,
- Infertility Treatment, not including testing leading up to diagnosis and corrections to correct the defect preventing conception,
- Long Term Care,
- Non-emergency care when traveling outside the U.S.,
- Private Duty Nursing,
- Routine eye care (Adult), except for diabetic exams, limited to 1 per year, and
- Weight Loss Programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery,	• Chiropractic Care, $50 copayment for office evaluation/deductible does not apply; other services 30% coinsurance. 50% coinsurance for out-of-network. Spinal manipulations limited to 25 visits per year, and	• Dialysis Services (outpatient) are limited to 125% of the Medicare allowable rate; 30% coinsurance. In-network benefits apply out-of-network, • Hearing Aids, limited to 1 per ear every 3 years, and • Routine Foot Care, *effective 10/2/19*.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-866-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: MedBen's Customer Service Department at 1-800-686-8425 or mbaccess.medben.com (select MedBen Access). Additionally, a consumer assistance program may be available in your state to help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and at http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/. Contact: Tennessee Department of Commerce & Insurance, 500 James Robertson Parkway, Davy Crockett Tower, 4th floor, Nashville, TN 37243-0565 or by phone at 1-615-741-2241, online at http://www.tn.gov/commerce/section/consumer-services.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-862-6704.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,200
Copayments	$20
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$600
The total Peg would pay is	**$4,820**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *copayment*	$50
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Confirmation of Benefit Changes Effective 7/1/19
Anderson County Government

The Gold Plan Emergency Room – Hospital Services benefit will be updated to the following:

$500 copay / then paid at 100%

This is for both bona-fide emergency and non-emergency.
This is for both the in and out of network levels.

The undersigned, a representative of the Plan Administrator, has requested that the above changes be made to the referenced Plan(s). Upon my signature below, I hereby authorize MedBen to make the requested amendments. I understand that the language used in amending the Plan and its respective SPD may not exactly match the language used above. I also understand that the information on this form will be used to determine eligibility, process claims and answer customer service inquiries. I hereby agree to indemnify and hold MedBen harmless for any claims or losses that may arise from its use of this information.

Kim Jeffers-Whitaker _____ 12/26/2019

Signature **Date**

ANDERSON COUNTY GOVERNMENT
EMPLOYEE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

REVISED EFFECTIVE JULY 1, 2019
(unless otherwise noted)

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE COUNTY AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

NON-DISCRIMINATION NOTICE

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

Anderson County Government does not exclude people or treat them differently because of race, color, national origin, age, disability or sex. Anderson County Government provides:

A. free aids and services to people with disabilities to communicate effectively with us;
B. written information in other formats (large print, audio, accessible electronic formats, other formats); and
C. free language services to people whose primary language is not English.

If you need these services, contact Kim Jeffers-Whitaker, Anderson County Government's Civil Rights Coordinator. If you believe that Anderson County Government has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Kim Jeffers-Whitaker, Anderson County Government's Civil Rights Coordinator, at 100 N. Main St, Room 102 Clinton, TN 37716 or call 865-264-6300, send a fax to 865-264-6259, or e-mail at kwhitaker@andersontn.org.

You can file a grievance in person or by mail, fax or e-mail. If you need help filing a grievance, Anderson County Government's Civil Rights Coordinator 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/portal/lobby.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, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-865-264-6300 (TTY: 1-865-264-6300).

لعربية (Arabic):
(رقم 865-264-6300ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- هاتف الصم والبكم: 1-865-264-6300.)

繁體中文 (Chinese): 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 1-865-264-6300（TTY：1-865-264-6300).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-865-264-6300 (TTY: 1-865-264-6300).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-865-264-6300 (TTY: 1-865-264-6300)번으로 전화해 주십시오.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-865-264-6300 (ATS : 1-865-264-6300).

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-865-264-6300 (TTY: 1-865-264-6300).

አማርኛ (Amharic): ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-865-264-6300 (መስማት ለተሳናቸው: 1-865-264-6300).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-865-264-6300 (TTY: 1-865-264-6300).

ગુજરાતી (Gujarati): □ચુના: જો તમે □જરાતી બોલતા હો, તો િન:□લ્કુ ભાષા સહાય સેવાઓ તમારા માટ□ ઉપલબ્ધ છ. ફોન કરો 1-865-264-6300 (TTY: 1-865-264-6300).

日本語 (Japanese): 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。1-865-264-6300（TTY:1-865-264-6300）まで、お電話にてご連絡ください。

Tagalog (Tagalog): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-865-264-6300 (TTY: 1-865-264-6300).

हिंदी (Hindi): ध्यान द□: य□द आप □हदी बोलते ह □तो आपके ि लए मुफ्त म□ भाषा सहायता सेवाएं उपलब्ध ह।□ 1-865-264-6300 (TTY: 1-865-264-6300) पर कॉल कर□।

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-865-264-6300 (телетайп: 1-865-264-6300).

Persian فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY: 1-865-264-6300) 1-865-264-6300 تماس بگیرید.

MEDICAL BENEFITS ADMINISTRATORS, INC.

Established in 1989, Medical Benefits Administrators, Inc. (MBA) is a subsidiary of Medical Benefits Mutual Life Insurance Co., one of the oldest health insurance firms in the United States. In 1938, the Company entered the insurance business operating under the name Hospital Services Association. Later, it became known as HSA of Ohio.

The name, Medical Benefits Mutual, was adopted in 1987, signaling the Company's establishment as a full-fledged mutual life insurance company. Medical Benefits Administrators, Inc. builds on this great service tradition and commitment to the future by delivering the services the marketplace demands.

MBA is pleased to have been chosen as your Benefit Manager. MBA is committed to the fundamental criteria that distinguish us from the crowd. The first is a commitment to excellent claims administration. The second is a commitment to long term relationships with the people we serve.

We will appreciate your comments and strive to make any dealings with us as simple as possible. If you have any questions about a claim, we invite you to call us at (800) 423-3151, e-mail us at medben@medben.com or to drop in at our offices at 1975 Tamarack Road, Newark, Ohio 43055.

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ARTICLE I

PLAN INFORMATION

NAME OF PLAN

The name of the Plan is the Anderson County Government Employee Benefit Plan. The provisions described in this document shall apply to Participants and their Dependents who are enrolled in either the Gold Plan option or the Silver Plan option, as described in Article II.

PURPOSE OF THE PLAN

Anderson County Government executes this document, including any amendments, to establish a health benefit plan for the exclusive benefit of its participating employees, County Commissioners and certain Retirees and their eligible Dependents and to grant them legally enforceable rights under this Plan. While Anderson County Government has every intention of continuing this Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a Summary Plan Description to each Participant that summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting the Participant and his or her covered Dependents.

PLAN EFFECTIVE DATE

The Plan Effective Date of this revision of the Plan is July 1, 2019, unless otherwise noted. This Plan was originally effective on July 1, 1984.

AMENDMENT OR TERMINATION

Anderson County Government may amend or terminate the Plan at any time by means of a writing signed by a person authorized by Anderson County Government to do so. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated by Anderson County Government to the Participants.

Upon Plan termination, any Plan assets remaining in the Plan's account(s) will be distributed by the Plan Administrator to the Plan Sponsor and/or Participants, in accordance with method(s) set forth in any applicable law or regulation. The Plan Administrator shall pay all eligible Plan benefits and expenses before any distribution is made.

The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.

Anderson County Government reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)

62-6000477

PLAN ADMINISTRATOR

Anderson County Government
100 North Main Street, Suite 102
Clinton, TN 37716
(865) 264-6300

GROUP NUMBER

10529

PLAN YEAR
The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements. The Plan Year will begin on July 1st and end on June 30th of the following year.

CALENDAR YEAR
The Calendar Year is the period beginning January 1st and ending December 31st that is used in the application of Deductible, Out-of-Pocket and benefit maximum amounts.

TYPE OF ADMINISTRATION
Contract Administration.

DESCRIPTION OF PLAN
The Plan is an employee health and welfare benefit plan providing medical benefits utilizing a Preferred Provider network, and prescription drug benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of this Plan and the actual provisions of the Plan document, the Plan document shall govern.

This Plan is self-funded by the County, and administered in accordance with applicable provisions of Tennessee law. The state insurance laws of Tennessee only apply to the extent that such laws specifically include self-funded Tennessee non-federal governmental plans.

The Plan shall not be deemed to constitute a contract between the County and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the County or to interfere with the right of the County to discharge any employee at any time.

NAMED FIDUCIARY
Anderson County Government
100 North Main Street, Suite 102
Clinton, TN 37716
(865) 264-6300

AGENT FOR SERVICE OF LEGAL PROCESS
Anderson County Government
100 North Main Street, Suite 102
Clinton, TN 37716
(865) 264-6300

In addition, service of legal process may be made upon the Plan Administrator or a Plan Trustee, if a Trustee has been appointed.

FUNDING
The Plan is funded by the Employer. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid.

ASSIGNMENT
A Covered Person's benefits may not be assigned, except by consent of the County, other than to Providers of Plan benefits.

SOURCE OF CONTRIBUTIONS
The Plan is funded by contributions made by the Employer and employees who are participating under the Plan. Participant Contributions are currently required for both Participant and Dependent Coverage.

The County shall, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants for each type of coverage.

BENEFIT MANAGER
Medical Benefits Administrators, Inc.
1975 Tamarack Road
P. O. Box 1099
Newark, Ohio 43058-1099
(740) 522-8425
(800) 423-3151
www.medben.com

UTILIZATION REVIEW SERVICE
Through September 30, 2019:
Hines and Associates
(800) 735-1200

Effective October 1, 2019:
Cigna
(800) 686-8425

GRANDFATHERED STATUS UNDER PPACA
This Plan is currently considered to be non-grandfathered for the purposes of the Patient Protection and Affordable Care Act.

ARTICLE II
SCHEDULE OF BENEFITS

2.1 COVERAGES AVAILABLE UNDER THIS PLAN

This Plan will allow Participants and their eligible Dependents to select from either of the following health care options:

A. the Gold Plan option; or

B. the Silver Plan option.

Both options include medical and prescription drug coverage. A Participant can choose from either of the above coverage options. The coverage described below shall only apply to a Covered Person to the extent that the Covered Person has been properly enrolled in, and coverage has become effective for, one of the above coverage options, as described in Article V.

2.2 SCHEDULE OF MEDICAL BENEFITS

This Plan provides a higher level of benefits when a Covered Person uses a Preferred Provider for covered services described under this Schedule of Benefits and the Plan. Covered Expenses for services obtained from Preferred Providers are paid at the In-Network (Preferred Provider) level of benefits shown in this Article. Services provided by non-Preferred Providers are considered at the Out-of-Network (non-Preferred Provider) level of benefits, unless one (1) or more of the following conditions are met:

A. the Covered Person who is either a full-time student or a Dependent child that is under the custody of an individual not enrolled in the Plan who resides outside of the service area of the Preferred Provider network, as determined by the Plan Administrator;

B. the Covered Person requires treatment in an Emergency and cannot reasonably obtain such treatment from a Preferred Provider or cannot express a Provider preference due to his or her medical condition. The In-Network level of benefits will apply until the Covered Person's condition has sufficiently stabilized so that transfer to a Preferred Provider for any required continued treatment is reasonably possible;

C. the Covered Person requires Medically Necessary services or supplies while traveling outside of the service area of the Preferred Provider network. This provision shall not apply if the reason for the travel was to obtain such services or supplies;

D. the Covered Person requires Medically Necessary services or supplies, and there is no Preferred Provider reasonably available in the Preferred Provider network who is qualified to provide such services, as determined by the Plan Administrator;

E. diagnostic tests are collected or taken on a Covered Person in a Preferred Provider's office, that are then sent to an outside facility for processing and/or interpretation; or

F. the Covered Person receives professional services for pathology, radiology or anesthesiology, or the services of an emergency room Physician or Hospitalist at a Preferred Provider Hospital or other Preferred Provider Facility.

In any of the above described situations, such charges will be considered at the In-Network level of benefits described in this Article.

The Preferred Providers have agreed to provide services and supplies to Covered Persons under this Plan in accordance with a previously determined discounted fee schedule or pursuant to a direct health care Provider contract. The provisions of these agreements with the Preferred Providers allow Covered Persons to benefit from these discounted fees. After the Plan has paid the appropriate benefits to a Preferred Provider based on such fees, these Providers have agreed not to bill a Covered Person under this Plan for the amount above the discounted fee. Of course, the Covered Person's Deductible, Copayments and Coinsurance will still be applied as described in this Plan.

The Plan will determine Covered Expenses for non-Preferred Providers based upon the Reasonable and Customary fee for the services. In many cases, the amount that would be considered as

Reasonable and Customary will be in excess of the fee that a Preferred Provider would charge for the same service under the Plan. This means that the Covered Person may be responsible for an increased dollar amount if an Out-of-Network Provider is utilized. In addition, the payment of any amount in excess of the Reasonable and Customary fee shall be the responsibility of the Covered Person in addition to the Deductibles and Coinsurance otherwise applicable under this Plan.

The Plan Administrator will provide, at no cost, a directory of the Preferred Providers.

This Schedule of Medical Benefits is intended to provide only a general description of a Covered Person's medical benefits. This Plan contains limitations and restrictions that are described later in this booklet and could affect any benefits that may be payable.

2.3 MEDICAL DEDUCTIBLE

	In-Network	Out-of-Network
Gold Option		
Individual Calendar Year Deductible	$1,000.00	$2,000.00
Family Calendar Year Deductible Limit	$2,000.00	$4,000.00
Silver Option		
Individual Calendar Year Deductible	$2,000.00	$3,000.00
Family Calendar Year Deductible Limit	$4,000.00	$6,000.00

The In-Network Deductible shall not apply to the Out-of-Network Deductible, or vice versa. There is a separate Deductible applicable to the prescription drug card and mail order prescription programs, as described in Section 2.9.

2.4 PREFERRED PROVIDER COPAYMENT

Gold Option

A Copayment of twenty-five dollars ($25.00) shall apply to charges made by a Preferred Provider Primary Care Physician for an office visit, not including office visits for wellness services, including Recommended Wellness Services, or transplant related office visits. If the office visit is with a Specialist, a Copayment of forty dollars ($40.00) shall apply. The Deductible listed in Section 2.3 shall not apply to the office visit charges. The balance of the charges for the office visit, and certain services performed in the office during the same visit will be paid at one hundred percent (100%). For office-based surgery and medical supplies/services performed during the visit, the balance of the Covered Expenses for such services will be paid as described in Section 2.6. Copayments may also apply to other services and supplies under this Plan, as described in Section 2.6. If more than one (1) total Copayment applies during the same visit, Copayments will be limited to the highest Copayment that would otherwise apply.

Silver Option

A Copayment of thirty-five dollars ($35.00) shall apply to charges made by a Preferred Provider Primary Care Physician for an office visit, not including office visits for wellness services, including Recommended Wellness Services, or transplant related office visits. If the office visit is with a Specialist, a Copayment of fifty dollars ($50.00) shall apply. The Deductible listed in Section 2.3 shall not apply to the office visit charges. The balance of the charges for the office visit, and certain services performed in the office during the same visit will be paid at one hundred percent (100%). For office-based surgery and medical supplies/services performed during the visit, the balance of the Covered Expenses for such services will be paid as described in Section 2.7. Copayments may also apply to other services and supplies under this Plan, as described in Section 2.7. If more than one (1) total Copayment applies during the same visit, Copayments will be limited to the highest Copayment that would otherwise apply.

2.5 MEDICAL COINSURANCE AND OUT-OF-POCKET LIMITS

Gold Option	
In-Network (Preferred Provider) Coinsurance	80%
Out-of-Network (Non-Preferred Provider) Coinsurance	50%
Silver Option	
In-Network (Preferred Provider) Coinsurance	70%
Out-of-Network (Non-Preferred Provider) Coinsurance	50%

See Section 2.6, Medical Copayment and Coinsurance Amounts – Gold Option, for Coinsurance amounts that vary from this standard if enrolled in the Gold Plan option, or Section 2.7, Medical Copayment and Coinsurance Amounts – Silver Option, if enrolled in the Silver Plan option.

Calendar Year Out-of-Pocket Limits

	In-Network *(including medical Deductibles, medical Copayments and the Covered Person's share of Coinsurance paid at the In-Network level)*	Out-of-Network *(including medical Deductibles and the Covered Person's share of Coinsurance paid at the Out-of-Network level)*
Gold Option		
Per Individual	$3,000.00	$9,000.00
Per Family	$6,000.00	$18,000.00
Silver Option		
Per Individual	$4,000.00	$18,000.00
Per Family	$8,000.00	$36,000.00

Charges related to services and supplies that are not Covered Expenses under this Plan, in excess of any Reasonable or Customary limits, or other Plan limitations, or attributable to any Plan penalty will not apply to the Out-of-Pocket limits listed above. Amounts applied to the In-Network Out-of-Pocket limits will not apply to the Out-of-Network Out-of-Pocket limits, or vice versa. A separate Out-of-Pocket maximum applies to the prescription drug card and mail order prescription programs, as described in Section 2.9.

2.6 MEDICAL COPAYMENT AND COINSURANCE AMOUNTS – GOLD OPTION

Deductibles are applied on a Calendar Year basis, while Copayments will be applied on a per visit or per service basis, and both reflect amounts to be paid by the Covered Person. Coinsurance reflects the percentage amount of Covered Expenses to be paid by the Plan after any applicable Deductible or Copayment.

Gold Option	**In-Network**			**Out-of-Network**	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Tobacco Cessation Counseling①	None	None	100%	Applies	50%

Gold Option	In-Network			Out-of-Network	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
FDA Approved Contraceptives for Females, including Contraception Related Medical Services	None	None	100%	Applies	50%
Nutritional Counseling Services①	None	None	100%	Applies	50%
Breast Feeding Equipment and Related Supplies①	None	None	100%	*Not Covered*	
Lactation Counseling①	None	None	100%	Applies	50%
Retinopathy Vision Screening for Diabetics①	None	Applies	80%	Applies	50%
Other Routine Eye Examinations/ Visual Acuity Screening①	None	None	100%	Applies	50%
Elective Sterilizations					
All Covered Females	None	None	100%	Applies	50%
Male Participants/Spouses	None	Applies	80%	Applies	50%
Other Covered Wellness Services, including Recommended Wellness Services①	None	None	100%	Applies	50%
Office Visits, including Injections/Administration of Injections and Diagnostic/ Laboratory Services During Same Visit *(includes Telehealth visits)*					
Primary Care Physician (PCP)	$25.00	None	100%	Applies	50%
Specialist	$40.00	None	100%	Applies	50%
Office-Based Services & Supplies if No Office Visit Charged					
Allergy Injections, the Administration of Injections & Serum/Venom					
Primary Care Physician	$25.00	None	100%	Applies	50%
Specialist	$40.00	None	100%	Applies	50%
Other Injections & the Administration of Injections	None	Applies	80%	Applies	50%
Diagnostic & Laboratory Services	None	Applies	80%	Applies	50%
Other Office-Based Services, whether or Not Office Visit Charged					
Surgery	None	Applies	80%	Applies	50%
Medical Supplies	None	Applies	80%	Applies	50%
Other Medical Services Not Listed Elsewhere	None	Applies	80%	Applies	50%
Outpatient Hospital/Facility Services	None	Applies	80%	Applies	50%

Gold Option	In-Network			Out-of-Network	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Chiropractic Services①					
Office Visit for Evaluation	$50.00	None	100%	Applies	50%
Other Covered Services, including Diagnostics & Manipulations①	None	Applies	80%	Applies	50%
Urgent Care Services *(per visit)*	$50.00	None	100%	Applies	50%
Emergency Room Services					
Facility Charges *(per visit, Copayment waived if admitted)*	$500.00	Applies	80%	*Paid at In-Network Level*	
Physicians Charges	None	Applies	80%	*Paid at In-Network Level*	
Ambulance Services	None	Applies	80%	*Paid at In-Network Level*	
Other Physician's Charges Not Listed Elsewhere	None	Applies	80%	Applies	50%
Hospital Room & Board, Intensive Care Units②	None	Applies	80%	Applies	50%
Other Hospital Expenses	None	Applies	80%	Applies	50%
Outpatient Dialysis③	None	Applies	80%	*Paid at In-Network Level*	
Bereavement Counseling					
Through October 1, 2019	None	None	100%	Applies	50%
Effective October 2, 2019	*Paid Same as Other Illness*			Applies	50%
Mental/Nervous Disorders, Alcoholism & Substance Abuse					
Office Visits and Individual & Group Counseling	$25.00	None	100%	Applies	50%
Intensive Outpatient Psychotherapy	None	Applies	80%	Applies	50%
Other Covered Services & Supplies	*Paid Same as Other Illness*			Applies	50%
Organ & Tissue Transplants *(other than cornea)*					
Services/Supplies through a Special Transplant Network Facility	None	Applies	80%	*Not Applicable*	
Travel, Transportation, Meals & Lodging①	None	None	100%	*Not Applicable*	
Services/Supplies through a Non-Transplant Network Facility	None	Applies	80%	Applies	50%
Specialty Drugs Administered by a Provider	None	None	100%	Applies	50%
Other Covered Services & Supplies①	None	Applies	80%	Applies	50%

EXPLANATION

① Please see additional limitations in Section 2.8, Medical Plan Benefit Maximums.

② Covered Expenses for Hospital Room & Board will be determined based on the Hospital's daily Semi-Private room rate. Charges for Intensive Care Units will be considered at the Reasonable and Customary charge for such a unit.

③ There is no network for these Outpatient services. The Reasonable and Customary amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the maximum payable amount applicable to the treatment, supplies, and/or services, which typically is one hundred twenty-five percent (125%) of the current Medicare allowable fee for the appropriate area. Dialysis services include kidney dialysis and dialysis related claims. Effective October 1, 2019, this provision shall only apply to Covered Persons who are either full-time students or Dependent children that are under the custody of an individual not enrolled in the Plan who resides outside of the service area of the Preferred Provider network, as determined by the Plan Administrator, as described in Section 2.2A.

2.7 MEDICAL COPAYMENT AND COINSURANCE AMOUNTS – SILVER OPTION

Deductibles are applied on a Calendar Year basis, while Copayments will be applied on a per visit or per service basis, and both reflect amounts to be paid by the Covered Person. Coinsurance reflects the percentage amount of Covered Expenses to be paid by the Plan after any applicable Deductible or Copayment.

Silver Option	**In-Network**			**Out-of-Network**	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Tobacco Cessation Counseling①	None	None	100%	Applies	50%
FDA Approved Contraceptives for Females, including Contraception Related Medical Services	None	None	100%	Applies	50%
Nutritional Counseling Services①	None	None	100%	Applies	50%
Breast Feeding Equipment and Related Supplies①	None	None	100%	*Not Covered*	
Lactation Counseling①	None	None	100%	Applies	50%
Retinopathy Vision Screening for Diabetics①	None	Applies	70%	Applies	50%
Other Routine Eye Examinations/ Visual Acuity Screening①	None	None	100%	Applies	50%
Elective Sterilizations					
All Covered Females	None	None	100%	Applies	50%
Male Participants/Spouses	None	Applies	70%	Applies	50%
Other Covered Wellness Services, including Recommended Wellness Services①	None	None	100%	Applies	50%
Office Visits, including Injections/Administration of Injections and Diagnostic/ Laboratory Services During Same Visit *(includes Telehealth visits)*					
Primary Care Physician (PCP)	$35.00	None	100%	Applies	50%
Specialist	$50.00	None	100%	Applies	50%

Silver Option	**In-Network**			**Out-of-Network**	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Office-Based Services & Supplies if No Office Visit Charged					
Allergy Injections, the Administration of Injections & Serum/Venom					
Primary Care Physician	$35.00	None	100%	Applies	50%
Specialist	$50.00	None	100%	Applies	50%
Other Injections & the Administration of Injections	None	Applies	70%	Applies	50%
Diagnostic & Laboratory Services	None	Applies	70%	Applies	50%
Other Office-Based Services, whether or Not Office Visit Charged					
Surgery	None	Applies	70%	Applies	50%
Medical Supplies	None	Applies	70%	Applies	50%
Other Medical Services Not Listed Elsewhere	None	Applies	70%	Applies	50%
Outpatient Hospital/Facility Services	None	Applies	70%	Applies	50%
Chiropractic Services①					
Office Visit for Evaluation	$50.00	None	100%	Applies	50%
Other Covered Services, including Diagnostics & Manipulations①	None	Applies	70%	Applies	50%
Urgent Care Services *(per visit)*	$75.00	None	100%	Applies	50%
Emergency Room Services	None	Applies	70%	*Paid at In-Network Level*	
Ambulance Services	None	Applies	70%	*Paid at In-Network Level*	
Other Physician's Charges Not Listed Elsewhere	None	Applies	70%	Applies	50%
Hospital Room & Board, Intensive Care Units②	None	Applies	70%	Applies	50%
Other Hospital Expenses	None	Applies	70%	Applies	50%
Outpatient Dialysis③	None	Applies	70%	*Paid at In-Network Level*	
Bereavement Counseling					
Through October 1, 2019	None	None	100%	Applies	50%
Effective October 2, 2019	*Paid Same as Other Illness*			Applies	50%
Mental/Nervous Disorders, Alcoholism & Substance Abuse					
Office Visits and Individual & Group Counseling	$35.00	None	100%	Applies	50%
Intensive Outpatient Psychotherapy	None	Applies	70%	Applies	50%
Other Covered Services & Supplies	*Paid Same as Other Illness*			Applies	50%

Silver Option	In-Network			Out-of-Network	
	Copayment	Deductible	Coinsurance	Deductible	Coinsurance
Organ & Tissue Transplants *(other than cornea)*					
Services/Supplies through a Special Transplant Network Facility	None	Applies	70%	*Not Applicable*	
*Travel, Transportation, Meals & Lodging*①	None	None	100%	*Not Applicable*	
Services/Supplies through a Non-Transplant Network Facility	None	Applies	70%	Applies	50%
Specialty Drugs Administered by a Provider	None	None	100%	Applies	50%
Other Covered Services & Supplies①	None	Applies	70%	Applies	50%

EXPLANATION

① Please see additional limitations in Section 2.8, Medical Plan Benefit Maximums.

② Covered Expenses for Hospital Room & Board will be determined based on the Hospital's daily Semi-Private room rate. Charges for Intensive Care Units will be considered at the Reasonable and Customary charge for such a unit.

③ There is no network for these services. The Reasonable and Customary amount which, at the Plan Administrator's sole discretion and if applicable, will not exceed the maximum payable amount applicable to the treatment, supplies, and/or services, which typically is one hundred twenty-five percent (125%) of the current Medicare allowable fee for the appropriate area. Dialysis services include kidney dialysis and dialysis related claims. Effective October 1, 2019, this provision shall only apply to Covered Persons who are either full-time students or Dependent children that are under the custody of an individual not enrolled in the Plan who resides outside of the service area of the Preferred Provider network, as determined by the Plan Administrator, as described in Section 2.2A.

2.8 MEDICAL PLAN BENEFIT MAXIMUMS

The medical plan benefit maximums and limitations are shown below. Amounts applied to any Calendar Year or Lifetime maximums under any Plan option offered by the County will also apply to similar limits under any other Plan option offered by the County.

Wellness Services	
Routine Hearing & Eye Examinations/ Visual Acuity Screening	Through age twenty-one (21)
Retinopathy Vision Screening for Diabetics	One (1) exam per Calendar Year
Cologuard Testing	One (1) test every three (3) Calendar Years
Breastfeeding Equipment & Supplies	One (1) manual breast pump per Pregnancy Preferred Provider Only

Lactation Counseling	*Through October 1, 2019,* one (1) visit per Pregnancy *Effective October 2, 2019*, three (3) visits per Pregnancy
Nutritional Counseling Services	Twelve (12) visits per Calendar Year Only for Covered Persons diagnosed with hyperlipidemia, hypertension, obesity, type two (2) diabetes, coronary artery disease and congestive heart failure
Tobacco Cessation Counseling Services	Eight (8) visits per Calendar Year and only if performed in a primary care setting
Chiropractic Services	Twenty-five (25) visits per Calendar Year
Spinal Pain Injections	Three (3) per site per rolling twelve (12) months, unless prior authorization proves additional injections to be Medically Necessary
Physical, Occupational & Speech Therapy *(regardless if provided through home health care)*	Twenty-five (25) visits each, per Calendar Year, unless prior authorization proves additional visits to be Medically Necessary
Cardiac Rehabilitation & Pulmonary Therapy Services	Thirty-six (36) visits each, per Calendar Year, unless prior authorization proves additional visits to be Medically Necessary
Autism Services, including ABA Therapy	Under age twelve (12)
Left & Right Hearing Aids	One (1) per ear every three (3) years
Prosthetic Bras after Mastectomy	Four (4) bras per Calendar Year
Wigs following Chemotherapy and Other Radiation Therapy Services	One (1) wig per Calendar Year
Skilled Nursing/Extended Care Facility, including Rehabilitation Facility	Sixty (60) days per Calendar Year
Diabetic Shoes & Custom Shoe Inserts	One (1) pair of shoes, or three (3) pairs of inserts per Calendar Year
Accidental Dental Services	Treatment must start within three (3) months of the accident and is covered for up to twelve (12) months following the accident

Travel, Transportation, Meals & Lodging for Organ & Tissue Transplants Through Special Transplant Network	One hundred and fifty dollars ($150.00) per day for meals & lodging, up to a maximum of ten thousand dollars ($10,000.00) for travel, transportation, meals & lodging, per transplant combined

2.9 SCHEDULE OF PRESCRIPTION DRUG CARD AND MAIL ORDER PRESCRIPTION PROGRAMS

The Plan has a prescription drug card program that covers prescriptions dispensed through a participating pharmacy and, for maintenance medications only, a mail order prescription drug service. The Plan Administrator will provide a listing of the pharmacies that are participating in the prescription drug card program and the drugs that are considered formulary/preferred. The Plan will cover up to a maximum of a thirty (30) day supply per prescription under the prescription drug card program and up to a maximum of a ninety (90) day supply for maintenance drugs through the mail order program. Some prescriptions require prior authorization. Certain exclusions and limitations apply to the prescription programs. These are described in Section 10.4 of the Plan.

Prescriptions filled through Walgreens Pharmacy will not be covered under this Plan.

The applicable Deductible listed below must be met before the following Copayments apply, unless otherwise noted, up to the Out-of-Pocket limits listed at the end of this section.

DEDUCTIBLE

Gold Option	
Individual Calendar Year Deductible	$125.00
Family Calendar Year Deductible	$250.00
Silver Option	
Individual Calendar Year Deductible	$250.00
Family Calendar Year Deductible	$500.00

COPAYMENT

	30 Day Supply Through Retail *(Maintenance Drugs)*	30 Day Supply Through Retail *(All Other Drugs)*	90 Day Supply Through Mail Order *(Maintenance Drugs Only)*
FDA Approved Contraceptives for Females *(under age 55)* **and Tobacco Cessation Products** *(age 18+)***, Tamoxifen & Evista** *(age 35+)***, Bowel Preparation Kits used with Colonoscopies** *(age 50-75)***, Statins and Other Products included in the Recommended Wellness Services**	None, Deductible does not apply	None, Deductible does not apply	None, Deductible does not apply
Influenza, Shingles *(age 50+ for Shingrix & age 60+ for Zostavax)*	None, Deductible does not apply	Not Applicable	Not Applicable

Other Generic Equivalent Prescription Drugs	$10.00	$10.00	$20.00
Other Brand Name Prescription Drugs			
On Formulary/Preferred Listing	$30.00	30% of the cost of the drug up to a maximum of $125.00	$60.00
Not on Formulary/Preferred Listing	$40.00	30% of the cost of the drug + $30.00 up to a maximum of $175.00	$80.00
Specialty Drugs	30% of the cost of the drug + $30.00 up to a maximum of $175.00		Not Covered

OUT-OF-POCKET LIMITS
(includes retail & mail order combined)

Gold Option	
Individual Calendar Year Deductible	$1,500.00
Family Calendar Year Deductible Limit	$3,500.00
Silver Option	
Individual Calendar Year Deductible	$2,000.00
Family Calendar Year Deductible Limit	$4,000.00

ARTICLE III
DEFINITIONS

All terms that are defined in this Article III are capitalized wherever they appear in this Plan.

3.1 GENERAL AND MEDICAL PLAN DEFINITIONS

ACTIVELY AT WORK or ACTIVE WORK

The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the County. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; a member of the Board of Directors; temporary, free-lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively at Work unless each meets the requirements specified in Section 5.2. This term shall not apply to any provision of this Plan to the extent that such application would be deemed to violate the requirements of HIPAA.

ACUTE

The term "Acute" means an illness or injury that is both severe and of short duration.

ADVANCED RADIOLOGICAL IMAGING

The term "Advanced Radiological Imaging" means services such as MRIs, CT scans, PET scans, nuclear medicine and similar technologies.

ADVERSE BENEFIT DETERMINATION

The term "Adverse Benefit Determination" means any of the following:

A. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan;

B. a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate;

C. a reduction or termination by the Plan Administrator of a previously approved course of treatment, other than by Plan termination or amendment; or

D. any retroactive rescission of coverage (other than due to the failure to make Participant Contributions, fraud or intentional misrepresentation of a material fact), whether or not there is an adverse effect on any particular benefit at that time.

ALCOHOLISM

The term "Alcoholism" means the taking of alcohol at dosages that place a Covered Person's welfare at risk, cause the Covered Person to endanger the public welfare and that constitute alcohol dependence.

In making the determination as to whether the Covered Person's condition meets the definition of Alcoholism under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

APPROVED CLINICAL TRIAL

The term "Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life Threatening Condition and is one (1) of the following:

A. a federally funded trial that is approved or funded, including in-kind contributions, by one (1) or more of the following entities:
   1. the Centers for Disease Control and Prevention;
   2. the Agency for Health Care Research and Quality;
   3. the Centers for Medicare & Medicaid Services;
   4. the National Institutes of Health;
   5. a cooperative group or center of any of the above entities or the United States Department of Defense or the United States Department of Veterans' Affairs;
   6. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
   7. any of the following if the clinical trial has been approved through a system of peer review that the Secretary of Health and Human Services determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
      a. the United States Department of Energy;
      b. the United States Department of Veterans' Affairs; and
      c. the United States Department of Defense;

B. a clinical trial conducted under an FDA investigational new drug application reviewed by the FDA; or

C. a drug trial that is exempt from the requirement of an FDA investigation new drug application.

BENEFIT MANAGER

The term "Benefit Manager" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Benefit Manager is appointed or retained (as a result of the termination or expiration of such agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Manager in writing, the term will mean the Plan Administrator. The Benefit Manager is not the Plan fiduciary and does not have final discretion under any Plan provisions, including claims determinations.

As of the Plan Effective Date of this revision of the Plan, the Benefit Manager of the Plan is Medical Benefits Administrators, Inc.

CALENDAR YEAR

The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. midnight, through the next December 31st.

CHIP

The term "CHIP" means the State Children's Health Insurance Program established under title XXI if the Social Security Act (42 U.S.C. 1396 et. Seq.).

CLEAN CLAIM

The term "Clean Claim" means a billing for a service and/or supply that is submitted to the Plan by a Covered Person or Provider that has no defect, impropriety or special circumstance, including incomplete documentation, that delays timely payment. It must clearly identify the Covered Person receiving the services or supplies and the Plan to which it is being submitted, and be submitted on an appropriate form that has been properly and entirely completed, as described in Section 4.1 and Section 4.2, including all data elements required by the applicable form. If a claim that has been submitted to this Plan is determined by the Plan Administrator to not constitute a Clean Claim

within this definition, the Covered Person and/or the Provider will be notified of the defects, and it will not be considered to have been received by the Plan until all required information is received.

CLOSE RELATIVE
The term "Close Relative" means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in- law.

COBRA
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE
The term "Coinsurance" means the specific percentage of the Covered Expenses that the Plan will pay, after any applicable Deductible or Copayments are taken. The Covered Person must pay the balance of the Covered Expenses after the Coinsurance has been applied, until the applicable Out-of-Pocket maximum is satisfied.

COMPLICATIONS OF PREGNANCY
The term "Complications of Pregnancy" means conditions requiring Hospital Confinement (when the Pregnancy is not terminated) whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy or caused by Pregnancy, such as Acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, non-elective caesarian section, ectopic Pregnancy that is terminated, and spontaneous termination of Pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct Complication of Pregnancy.

COPAYMENT
The term "Copayment" means a specific dollar amount (or percentage) of the Covered Expenses that the Covered Person must pay before the Plan pays benefits for a particular service or supply. A medical Copayment does not apply to any Deductible.

COSMETIC or COSMETIC SERVICE
The terms "Cosmetic" or "Cosmetic Service" mean any surgical or non-surgical treatment, drugs or devices intended to alter or reshape the body for the purpose of improving appearance or self-esteem.

COUNTY
The term "County" means Anderson County Government, the Plan sponsor.

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, or other charges that are specifically listed as covered under this Plan.

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 one (1) of the two (2) Plan options, as described in Article II.

CUSTODIAL CARE
The term "Custodial Care" means any services or supplies provided to assist an individual in the activities of daily living as determined by the Plan including but not limited to eating, bathing, dressing or other self-care activities.

CUSTOMARY
The term "Customary" refers to the designation of a charge as being the usual charge made by a Physician or other Provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other Providers rendering or furnishing such care or treatment within the same general geographic area, taking into consideration differences in demographics of specific locations and using generally accepted standards of medical practice. The term "area" in this definition means a county or such 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. In regards to services or supplies provided by Preferred Providers, this term refers to the contracted rate for the service or supply in question, as determined by the agreement between the Plan and the network to which the Provider belongs.

DEDUCTIBLE
The term "Deductible" means the amount of Covered Expenses Incurred by a Covered Person in a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

An Individual Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person.

A Family Deductible limit is the maximum amount that all Family members who are covered under the same Participant must pay in Deductible expense in a Calendar Year. Once this cumulative Family Deductible is reached, the Deductible will be considered satisfied for all Family members covered under the Plan during the remainder of the Calendar Year.

There is a separate Deductible that applies to expenses through the prescription drug card and mail order prescription programs, as described in Section 2.9.

DEPENDENT
The term "Dependent" means:

A. the Participant's legal spouse. Such spouse must have met all requirements of a valid marriage contract in the state in which such parties were married; or
B. the Participant's child who meets all of the following conditions:
    1. is the Participant's natural child, adopted child, stepchild, a child for whom the Participant or the Participant's spouse has Legal Guardianship or legal custody pursuant to a valid court order or is a child Placed For Adoption with the Participant or the Participant's spouse; and
    2. is less than twenty-six (26) years of age. The age requirement above is waived for any unmarried mentally or physically handicapped child who is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance, provided the child suffered such incapacity prior to attaining twenty-six (26) years of age. Proof of incapacity must be furnished to the Plan Administrator, or its designee, within thirty-one (31) days of the date the child's coverage would have ended due to age.

The Plan Administrator has the right to obtain sufficient proof of Dependent status from any Participant under the Plan who is requesting coverage of his or her Dependents.

This definition and all provisions of this Plan are intended to comply with state and federal law as both regard "Qualified Medical Child Support Orders" and "Medical Child Support Orders," as those terms are defined in the law. The Plan Administrator has established procedures governing "Qualified Medical Child Support Orders". Covered Persons under this Plan can receive upon request, free of charge, a copy of such procedures from the Plan Administrator.

The term "Dependent" excludes these situations:

A. a spouse who is legally separated or divorced from the Participant. Such separation/ divorce must have met all the requirements of a valid legal separation or divorce in the state granting it; or
B. any person who is covered under this Plan as an individual Participant or as the Dependent of another Participant.

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.

EFFECTIVE DATE
The term "Effective Date" means the date the Covered Persons coverage under this Plan begins.

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

A. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
B. serious impairment to bodily functions; or
C. serious dysfunction of any bodily organ or part.

EMPLOYER
The term "Employer" means the County and any entity that is affiliated with the County, as defined by any applicable state or federal statute, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the County. An Employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

ERISA
The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

ESSENTIAL HEALTH BENEFITS
The term "Essential Health Benefits" means, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories:

A. ambulatory patient services;
B. Emergency care;
C. hospitalization;
D. maternity and Newborn care;
E. Mental/Nervous Disorders, Alcoholism and Substance Abuse disorder services, including behavioral health treatment;
F. prescription drugs;
G. rehabilitative and habilitative services and devices;
H. laboratory services;
I. preventive and wellness services and chronic disease management; and
J. pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Tennessee as permitted by the Departments of Labor, Treasury, and Health and Human Services.

EXPERIMENTAL or INVESTIGATIVE

The terms "Experimental" or "Investigative" mean any treatment, procedure, drug, device, equipment and/or supplies (referred to as "service(s)" hereafter in this definition) to which any of the following applies:

A. it cannot be lawfully marketed without approval from the federal Food and Drug Administration (FDA) or other governmental agency and did not have approval at the time of its use for the purpose or manner in which it was used;

B. it is provided pursuant to a written protocol with objectives of determinations of safety, toxicity, effectiveness or effectiveness in comparison to conventional alternatives;

C. the predominant opinion of independent experts is that the service is Experimental or Investigative or not a generally accepted medical procedure; or

D. was not recognized by authoritative medical literature or studies to be non-Experimental and safe and effective for treating or diagnosing the condition for which it is used or proposed. Authoritative medical literature or studies include:

   1. at least two (2) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
   2. the following standard reference compendia, including:
      a. the *American Hospital Formulary Service-Drug Information*,
      b. the *American Medical Association Drug Evaluations,*
      c. the American Dental Association *Accepted Dental Therapeutics*, and
      d. the *United States Pharmacopoeia* drug information; or
   3. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the:
      a. Agency for Healthcare Research and Quality of the U.S. Department of Health and Human Services;
      b. National Institutes of Health;
      c. National Cancer Institute;
      d. National Academy of Sciences;
      e. Center for Medicare and Medicaid Services; and
      f. any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

This does not exclude coverage for Routine Patient Costs provided as part of an Approved Clinical Trial for the treatment of cancer or another Life Threatening Condition or disease for a Qualified Individual.

The Plan Administrator, in its sole discretion, shall determine whether or not a treatment, procedure, drug, device, equipment and/or supply is Experimental or Investigative under the Plan.

FAMILY

The term "Family" means a covered Participant and his or her covered Dependents.

FDA

The term "FDA" means the United States Food and Drug Administration, an agency of the United States Department of Health and Human Services that is charged with the responsibility for regulation and supervision of food safety, tobacco products, dietary supplements, prescription and over-the-counter pharmaceutical drugs (medications), vaccines, biopharmaceuticals, blood transfusions, medical devices, electromagnetic radiation emitting devices (ERED), cosmetics, animal foods & feed and veterinary products within the United States.

FINAL ADVERSE BENEFIT DETERMINATION
The term "Final Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan Administrator, in whole or in part, at the end of the internal appeals process described in Section 4.4.

FULL-TIME EMPLOYEE
The term "Full-Time Employee" means any employee who, on the date of hire, is reasonably expected to work, on average, at least thirty (30) hours per week (or one hundred thirty (130) hours per month) on an annual basis. Such an employee shall start his or her waiting period, if any, on the date of hire.

GENERIC DRUG
The term "Generic Drug" means a Prescription Drug that has the same active ingredients, strength or concentration, dosage form and route of administration as a Brand Name Drug. The FDA approves each Generic Drug as safe and as effective as a specific Brand Name Drug.

HEALTH CARE REFORM, PPACA, AFFORDABLE CARE ACT or ACA
The terms "Health Care Reform," "PPACA," "Affordable Care Act" or "ACA" mean the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as otherwise amended, including all current final regulations that are issued regarding such acts.

HEALTH INFORMATION
The term "Health Information" means any information, whether oral or recorded in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:
    1. the past, present or future physical or mental health or condition of an individual;
    2. the provision of health care to an individual; or
    3. the past, present or future payment for the provision of health care to an individual.

HIPAA
The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

HOSPITAL
The term "Hospital" means a facility which:

A. is licensed as a Hospital where licensing is required;
B. is open at all times;
C. is operated mainly to diagnose and treat illnesses or injuries on an Inpatient basis;
D. has a staff of one (1) or more Physicians on call at all times;
E. has twenty-four (24) hour-a-day nursing services by registered nurses (R.N.'s); and
F. has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental/Nervous Disorders, Alcoholism or Substance Abuse which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

HOSPITAL CONFINEMENT
The term "Hospital Confinement" means the time a Covered Person is treated as a registered bed patient at a Hospital or other Provider facility and incur a Room and Board charge.

HOSPITAL SERVICES
The term "Hospital Services" means Covered Services that are Medically Appropriate to be provided by an Acute care Hospital.

HOSPITALIST
The term "Hospitalist" means a Physician whose primary focus is the Medical Care of hospitalized patients. A Hospitalist's area of practice is based on the site of care (the Hospital) rather than by organ or body system, such as a cardiologist, or age, such as a pediatrician. Hospitalist activities may include patient care, teaching, research, and leadership related to Hospital care.

INCURRED
The term "Incurred" means that a Covered Expense is considered "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

IN-NETWORK
The term "In-Network" means Providers who are part of the Plan's Preferred Provider network at the time such Providers render services to Covered Persons that are Covered Expenses under this Plan. The Plan Administrator can provide a listing of Providers who are considered to be In-Network for the purposes of this Plan.

INPATIENT
The term "Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, Skilled Nursing Facility or other covered facility for treatment and charges are made for Room and Board to the Covered Person as a result of such admission.

JOINT COMMISSION
The term "Joint Commission" means an independent commission that accredits and certifies health care organizations and programs in the United States, including Hospitals, Skilled Nursing Facilities, ambulatory facilities, behavioral health facilities, laboratories, home health care agencies and pharmacies. To receive and maintain accreditation from the Joint Commission, an organization must undergo an on-site survey by a Joint Commission survey team at least every three (3) years. (Laboratories must be surveyed every two (2) years.) Information about the accreditation status of an organization can be found on the Joint Commission website (www.qualitycheck.org/consumer/searchQCR.aspx).

The Joint Commission was formerly known as the Joint Commission on Accreditation of Healthcare Organizations.

LEGAL GUARDIAN or LEGAL GUARDIANSHIP
The terms "Legal Guardian" or "Legal Guardianship" mean a person, or the status of a person and his or her ward, who has been appointed by a state court with specific jurisdiction over guardianships and estates, to have the care and management of a minor child. The Legal Guardian must have guardianship of the person of the minor child, and not merely the estate of such child. An order granting a person legal custody of a minor child, without the appointment of the person as the child's Legal Guardian, does not create a Legal Guardianship.

LIFE THREATENING CONDITION
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.

LIFETIME
The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime" means the total time period of a Covered Person's coverage under this Plan,

regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life.

MAINTENANCE CARE
The term "Maintenance Care" means medical services, Prescription Drugs, supplies and equipment for chronic, static or progressive medical conditions where the services:

A. fail to contribute toward a cure;
B. fail to improve unassisted clinical function;
C. fail to significantly improve health; and
D. are indefinite or long-term in nature.

Maintenance Care includes, but is not limited to, Prescription Drugs used to treat chemical and methadone dependency maintenance and skilled services/therapies.

MEASUREMENT PERIOD
The term "Measurement Period" means the look back period of time, as determined by the Plan Administrator, for use in determining whether Variable Hour Employees (and On-Going Employees who are not eligible under the provisions of Section 5.2 A) are employed for an average of at least thirty (30) hours per week and are therefore eligible for coverage under the Plan during the next applicable Stability Period. The Employer sponsoring this Plan uses an eleven (11) month Measurement Period starting on the date of hire for new employees, or a twelve (12) month Measurement Period beginning on May 1st and ending April 30th of the next Calendar Year for other employees. The Employer shall also establish a preliminary Measurement Period used to measure the hours of applicable employees during the first year the Employer uses such a measurement method.

If an employee experiences a break in service during a Measurement Period, the existing Measurement Period will resume once he or she returns to active employment with the Employer if the break in service is less than the period of active employment prior to the break, and less than thirteen (13) weeks in length. If the break in service is more than either the employee's total employment before the break, or thirteen (13) weeks, a new initial Measurement Period will commence once he or she resumes employment. Any such break in service that is attributable to FMLA, Service in the Uniformed Services, jury duty, or any other statutory continuation will be disregarded for the purposes of determining what the average number of hours of employment were during the entire Measurement Period.

The Employer will notify all new Variable Hour Employees who become eligible for coverage under this Plan within one (1) month of the end of the initial Measurement Period, and prior to the beginning of the initial Stability Period. On-Going Employees will be notified during the months of May or June each year as to their eligibility during the next applicable Stability Period.

MEDICAID
The term "Medicaid" means the program for medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et. seq.)

MEDICAL CARE
The term "Medical Care" means professional services given by a Physician or other Provider to treat an Injury, ailment, condition, disease, disorder or illness, including medical advice, treatment, medical diagnosis and the taking of prescription drugs.

MEDICALLY APPROPRIATE
The term "Medically Appropriate" means services that have been determined to be of value in the care of a specific Covered Person. To be Medically Appropriate, a service must be:

A. Medically Necessary;
B. consistent with generally accepted standards of medical practice for the Covered Person's medical condition;

C. provided in the most appropriate site and at the most appropriate level of service for the Covered Person's medical condition;

D. not provided solely to improve a Covered Person's condition beyond normal variation in individual development, appearance and aging; and

E. not for the sole convenience of the Provider, Covered Person or Covered Person's Family.

MEDICALLY NECESSARY or MEDICAL NECESSITY

The terms "Medically Necessary" or "Medical Necessity" mean procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgement, would provide to a Covered Person for the purpose of preventing, evaluating, diagnosing or treating an illness, Injury or disease or its symptoms, and that are:

A. in accordance with generally accepted standards of medical practice;

B. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Covered Person's illness, Injury or disease;

C. not primarily for the convenience of the Covered Person, Physician or other health care Provider; and

D. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Covered Person's illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

The fact that a Physician has prescribed, ordered, recommended or approved a service, treatment, hospitalization or supply does not, of itself, make such service, treatment, hospitalization or supply Medically Necessary under the Plan, nor does it make the charge a Covered Expense. The Plan reserves the right to make the final determination of Medical Necessity on the basis of final diagnosis and supporting medical data. This determination will be based on, and consistent with, standards approved by the Plan's medical review consultants.

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, B, C and D of Subchapter XVIII of the Social Security Act, as amended from time to time.

MENTAL/NERVOUS DISORDER

The term "Mental/Nervous Disorder" means any disease or condition that is classified as a mental disorder in the current edition of the *International Classification of Diseases*, published by the World Health Organization, or is listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, with the exception of disorders related to Alcoholism or Substance Abuse. Mental/Nervous Disorders include, but are not limited to:

A. psychotic disorders;

B. bipolar disorders; or

C. psychoneurotic disorders.

MULTIPLE SURGICAL PROCEDURES

The term "Multiple Surgical Procedures" means separate surgical procedures performed by a Physician on the same patient during the same operative session or during the same day. This term does not include procedures that are components of, or incidental to, a primary procedure, an intraoperative service or an incidental surgery.

For the purposes of determining Covered Expenses under this Plan, Multiple Surgical Procedures will be considered, as follows:

A. the Plan will consider as Covered Expenses up to one hundred percent (100%) of the Reasonable and Customary charge for the primary or highest valued procedure;
B. the Plan will consider as Covered Expenses up to fifty percent (50%) of the Reasonable and Customary charge for each additional procedure, for the second procedure through the fifth procedure; and
C. if more than five (5) procedures are performed in the same operative session/day, coverage of any additional procedures will be subject to the review and approval of the Plan Administrator, in its discretion. In order for any additional payment to be considered by the Plan under the provision, the operating Physician must submit the applicable operative notes.

Other restrictions and limitations may be applied to the payment of Multiple Surgical Procedures. Such restrictions and limitations will be consistent with the rules applied under the Medicare program, as listed in the most recent Medicare payment manuals.

NAMED FIDUCIARY
The term "Named Fiduciary" means the individual or entity that has the ultimate authority to control and manage the overall operation of the Plan.

NEVER EVENTS
The term "Never Events" means errors or omissions in Medical Care that are clearly identifiable, preventable, and serious in their consequences for patients. Examples of Never Events include, but are not limited to:

A. surgery on the wrong body part;
B. a foreign body left in a patient after surgery;
C. a mismatched blood transfusion;
D. a major medication error;
E. a severe "pressure ulcer" acquired in the Hospital;
F. falls or traumas experienced by a patient while confined in a healthcare facility; and
G. preventable post-operative deaths.

NEWBORN
The term "Newborn" means an infant from the date of birth until the earlier of the initial Hospital discharge or the last day of the mother's covered admission for a vaginal or cesarean delivery.

ON-GOING EMPLOYEE
The term "On-Going Employee" means any employee of the Employer who has been employed for at least one (1) full standard Measurement Period.

OPEN ENROLLMENT PERIOD
The term "Open Enrollment Period" means the period of time, as determined by the Plan Administrator, during which eligible employees and their Dependents may enroll in the Plan.

ORAL APPLIANCE
The term "Oral Appliance" means a device placed in the mouth and used to treat mild to moderate obstructive sleep apnea by repositioning or stabilizing the lower jaw, tongue, soft palate or uvula. An Oral Appliance may also be used to treat temporomandibular joint syndrome or dysfunction (TMJ or TMD) by stabilizing the jaw joint. An Oral Appliance is not the same as an occlusal splint, which is used to treat malocclusion or misalignment of teeth.

OUT-OF-NETWORK
The term "Out-of-Network" means Providers who are not part of the Plan's Preferred Provider network at the time such Providers render services to Covered Persons that are Covered Expenses under this Plan.

OUT-OF-POCKET
The term "Out-of-Pocket" means the amount of Covered Expenses that are the responsibility of the Covered Person and that accumulate towards the Plan's Out-of-Pocket maximum, not including amounts:

A. for Deductible expenses carried over from the prior Calendar Year under the provision described in Section 8.1;
B. for expenses that are not covered under this Plan;
C. in excess of the Reasonable and Customary charge for a service or supply;
D. in excess of any maximum benefit listed in the Plan; or
E. attributable to any penalty.

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, or at a Hospital, if not a registered bed patient at that Hospital or other covered facility.

PARTICIPANT
The term "Participant" means a person who meets the eligibility requirements listed in Section 5.2 and who is properly enrolled in the Plan.

PARTICIPANT CONTRIBUTION
The term "Participant Contribution" means that amount that is due from an eligible employee in order for that employee to obtain Participant and/or Dependent coverage(s) under the Plan. The County shall determine the amount of the Participant Contribution that may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

PHYSICIAN
The term "Physician" means a person licensed by the State to provide medical services. The services provided by a Physician must be within his or her specialty or scope of practice.

PLACED FOR ADOPTION or PLACEMENT FOR ADOPTION
The terms "Placed For Adoption" or "Placement For Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such Participant terminates upon the termination of such legal obligation.

PLAN
The term "Plan" means the sickness and accident plan, as described in and administered by the Anderson County Government Employee Benefit Plan.

PLAN ADMINISTRATOR
The term "Plan Administrator" means the entity 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 related services. Anderson County Government is the Plan Administrator as of the Plan Effective Date of this revision of the Plan.

PLAN EFFECTIVE DATE
The original Plan Effective Date of this Plan was July 1, 1984. The Plan Effective Date of this revision of the Plan is July 1, 2019, unless otherwise noted.

PLAN SPONSOR
The term "Plan Sponsor" means the entity that sponsors this Plan for the benefit of its own employees and their eligible Dependents, and the employees/Dependents of related Employers, if any. As of the Plan Effective Date, the Plan Sponsor is Anderson County Government.

PLAN YEAR
The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on July 1st and end on June 30th of the following year.

PRIMARY CARE PHYSICIAN or PCP
The terms "Primary Care Physician" or "PCP" mean a Physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. Primary Care Physicians include those trained and actively practicing in family practice, general practice, pediatrics, internal medicine or gynecology.

PREFERRED PROVIDER
The term "Preferred Provider" means a health care professional, group of professionals or medical facilities, that have agreed to provide medical services to a group of individuals for an agreed upon fee. The Plan will specify which professionals and/or facilities have Preferred Provider status. A list of Preferred Providers for this Plan will be provided by the Plan Administrator.

For the purposes of the organ and tissue transplant benefits, Preferred Provider includes Providers that are in this Plan's special transplant network. The specific amount of the benefits provided, and any limitations applied, will be determined based on the terms of the specific contract with this network.

PREGNANCY
The term "Pregnancy" means that physical state that results in childbirth, abortion or miscarriage, and any medical complications arising out of, or resulting from, such state.

PRESCRIPTION DRUG
The term "Prescription Drug" means a medication that may not be dispensed under applicable state or federal law without a Prescription.

PROTECTED HEALTH INFORMATION
The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and that is one (1) of the following:

A. transmitted by electronic media, including:
    1. the internet;
    2. an extranet;
    3. leased lines;
    4. dial-up lines;
    5. private networks; and
    6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
B. maintained in any electronic media; or
C. transmitted or maintained in any other form or medium.

PROTON BEAM THERAPY
The term "Proton Beam Therapy" means a type of radiation therapy that uses streams of protons (tiny particles with a positive charge) to kill tumor cells. Because it causes less damage to healthy tissue, Proton Beam Therapy is often used for cancers that are very close to critical parts of the body. It is used to treat cancers of the head and neck and organs such as the brain, eye, lung, and spine.

PROVIDER
The term "Provider" means a person or entity engaged in the delivery of health services who or that is licensed, certified or practicing in accordance with applicable state or federal laws.

QUALIFIED INDIVIDUAL
The term "Qualified Individual" means an individual who is properly enrolled in the Plan and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another Life Threatening Condition or disease. To be a Qualified Individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

QUALIFIED MEDICAL CHILD SUPPORT ORDER
The term "Qualified Medical Child Support Order" means a medical child support order, issued by a court of competent jurisdiction or state administrative agency that creates or recognizes the existence of a child's right to receive benefits for which a Covered Person is eligible under the Plan. Such order shall identify the Covered Person and each such child by name and last known mailing address, give a description of the type and duration of Coverage to be provided to each child and identify each health plan to which such order applies.

REASONABLE
The term "Reasonable" refers to the designation of a charge as being appropriate based on the services or supplies actually supplied by a Provider to a Covered Person. While the charge made for such service may be considered to be Customary within the general context of billing practices for similar services, the true circumstances of the case may warrant a lesser or higher charge than the Customary charge for the services and/or supplies that were, in fact, provided to the Covered Person. The Plan Administrator shall have the right to review Provider's records relative to the service or supply, and shall determine, in its absolute discretion, whether or not the charge made by the Provider for the service or supply is Reasonable. In making this determination, the Plan Administrator will take into consideration additional charges that were attributable to the errors, negligence or inefficiency of the Provider, and may consult with medical experts in the related fields to determine whether such charges would be considered Reasonable within the context in which they were provided.

RECOMMENDED WELLNESS SERVICE
The term "Recommended Wellness Service" means a service or supply that is not intended to treat an existing medical condition, but rather is intended to detect or prevent potential future problems or assist the Covered Person in maintaining his or her health. They are recommended by recognized medical bodies, and are required to be covered without cost sharing by non-grandfathered health plans under the Affordable Care Act if received through a Preferred Provider. These recommendations include the following:

A. evidence-based preventive services with an A or B recommendation from the U.S. Preventive Services Task Force (www.uspreventiveservicestaskforce.org);
B. immunizations recommended by the Advisory Committee on Immunization Practices, as updated annually (www.cdc.gov/vaccines); and
C. guidelines supported by the Health Resources and Services Administration that are applicable to children and women, including:

1. services provided to children under the Bright Futures recommendations of the American Academy of Pediatrics (brightfutures.aap.org) and the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) national recommendations on Newborn screening - See (www.hrsa.gov /advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html); and
2. women's health services recommendations developed by the Institute of Medicine (www.hrsa.gov/womens-guidelines).

Any changes to the above recommendations will take effect for this Plan at the beginning of the first Plan Year beginning one (1) year after the issuance of such new recommendation or a change in the existing recommendations by the above entities, unless the change was prompted by safety or other concerns that make it inadvisable to continue to cover the service or supply.

RETIREE
The term "Retiree" means an individual who has terminated from active employment with Anderson County Government and who meets the following requirements:

A. was actively employed cumulatively by Anderson County Government for at least thirty (30) years of service;
B. is under the age of sixty-five (65);
C. such termination from active employment with Anderson County Government occurred on or before December 31, 2018; and
D. was covered under this Plan as a Participant on the day before his or her retirement.

ROOM and BOARD
The term "Room and Board" refers to all charges, by whatever name called, that are made by a Hospital, Hospice or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

ROUTINE PATIENT COSTS
The term "Routine Patient Costs" means all items and services consistent with the coverage provided under the Plan that is typically covered for a Qualified Individual for treatment of cancer or another Life Threatening Condition or disease who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the Plan is not required under federal law to pay for the following:

A. the cost of the investigational item, device or service;
B. the cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and
C. the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SEMI-PRIVATE
The term "Semi-Private" refers to a class of accommodations in a Hospital or other covered facility in which at least two (2) patient beds are available per room.

SERVICE IN THE UNIFORMED SERVICES
The term "Service in the Uniformed Services" means performance of duty in the Armed Forces or Uniformed Services for a period of five (5) years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

SKILLED NURSING FACILITY
The term "Skilled Nursing Facility" means a facility that meets all of the following requirements:

A. it is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
B. its services are provided for compensation and under the full-time supervision of a Physician;
C. it provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;
D. it maintains a complete medical record on each patient;
E. it has an effective utilization review plan;
F. it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental/Nervous Disorders, Alcoholism or Substance Abuse disorders; and
G. it is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, Long-Term Acute Care Facility/Hospital or any other similar nomenclature.

SPECIALIST
The term "Specialist" means a Physician who primarily practices in any medical specialty, such as neurology, cardiology, or pulmonology, and who is not a Primary Care Physician.

SPECIALTY DRUG
The term "Specialty Drug" means a scientifically or "bioengineered" oral or injectable medicine that targets and treats a specific or "niche" condition, and includes one (1) or more of the following features:

A. it is usually a complex compound;
B. it is offered by the manufacturer at a premium price that is generally significantly higher than those for traditional medications;
C. it is primarily prescribed and administered by a Specialist, such as an oncologist or pulmonologist;
D. it often requires special or unique storage and handling; and
E. it requires disease management services, such as patient education and monitoring.

The Plan Administrator, in its discretion and in consultation with pharmaceutical experts, will determine if a drug is considered to be a Specialty Drug under this Plan.

STABILITY PERIOD
The term "Stability Period" means the period of time, as determined by the Plan Administrator, for which new Variable Hour Employees and On-Going Employees are eligible for coverage under the Plan, as determined during the latest prior Measurement Period. The Employer sponsoring this Plan uses a twelve (12) month Stability Period, starting thirteen (13) months from the date of hire for new Variable Hour Employees (and ending one (1) year later), or on July 1st and ending June 30th of the following Calendar Year for other employees. If a Variable Hour Employee is determined to work an average of at least thirty (30) hours per week during his or her initial Measurement Period following his or her date of hire, he or she will continue to be eligible for coverage during the current ongoing Stability Period from the end of such employees initial Measurement Period to the end of the current Stability Period (provided he or she is still employed by the Employer during

such Stability Period), even if determined to be ineligible during a subsequent overlapping Measurement Period.

If an employee becomes ineligible for coverage due to a break in service that occurs during a Stability Period for which coverage is being provided under this Plan, but returns to active employment with the Employer within thirteen (13) weeks and prior to the end of the same Stability Period, he or she will once again become eligible for coverage from the date he or she resumes active employment until the end of such Stability Period.

SUBSTANCE ABUSE
The term "Substance Abuse" means the taking of drugs (except those taken under the direction of a Physician or through a valid prescription) at dosages that place a Covered Person's welfare at risk, cause the Covered Person to endanger the public welfare and that constitute drug dependence.

In making the determination as to whether the Covered Person's condition meets the definition of Substance Abuse under this Plan, the Plan Administrator shall use recognized authorities, including designations contained in the most current editions of the *International Classification of Diseases* (ICD) of the World Health Organization and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association.

SUMMARY HEALTH INFORMATION
The term "Summary Health Information" means information that may be individually identifiable Health Information that:

A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and
B. from which the following information has been removed:
    1. names;
    2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
    3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
    4. telephone numbers;
    5. fax numbers;
    6. electronic mail addresses;
    7. social security numbers;
    8. medical record numbers;
    9. Plan identification numbers; or
    10. other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

SURGERY or SURGICAL PROCEDURE
The terms "Surgery" or "Surgical Procedure" mean Medically Necessary and Medically Appropriate surgeries or procedures. Surgeries involve an excision or incision of the body's skin or mucosal tissues, treatment of broken or dislocated bones, and/or insertion of instruments for exploratory or diagnostic purposes into a natural body opening.

TELEHEALTH
The term "Telehealth" means remote consultation that meets Medical Necessity criteria.

TOTALLY DISABLED or TOTAL DISABILITY
The terms "Totally Disabled" or "Total Disability" mean either:

A. a Participant who is prevented from performing his or her work duties and is unable to engage in any work or other gainful activity for which he or she is qualified or could reasonably become qualified to perform by reason of education, training, or experience because of Injury or disease; or

B. a Dependent who is prevented from engaging in substantially all of the normal activities of a person of like age and sex in good health because of non-occupational injury or disease.

URGENT CARE
The term "Urgent Care" means Medical Care or treatment that, if delayed or denied, could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function. Urgent Care is also Medical Care for treatment that, if delayed or denied, in the opinion of a Physician with knowledge of the claimant's condition, would subject the claimant to severe pain that cannot be adequately managed without the Medical Care or treatment.

USERRA
The term "USERRA" means the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended.

VARIABLE HOUR EMPLOYEE
The term "Variable Hour Employee" means any employee who, as of his or her date of hire:

A. is expected to work less than thirty (30) hours a week as of their date of hire, on average; or

B. for whom, on the date of hire, it cannot reasonably be determined whether or not the employee will work at least thirty (30) hours per week (or one hundred thirty (130) hours per month) as his or her hours vary from week to week for an indefinite period of time.

Variable Hour Employees include employees whose hours routinely vary from week to week, or employees whose hours vary depending on the season or time of year.

WAITING PERIOD
The term "Waiting Period" means the period of time that must pass before a Participant or Dependent is eligible to be covered for benefits under the Plan.

ARTICLE IV
CLAIM AND APPEAL PROCEDURES

4.1 INITIAL FILING OF CLAIMS

A Clean Claim for benefits should be filed within ninety (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that written notice and proof are given no later than one (1) year after the claim is Incurred, unless the Covered Person is legally incapacitated.

Upon termination of the Plan, final claims must be received within ninety (90) days of termination. In any of the events described above, notice and proof of claim will be determined at the discretion of the Plan Administrator, subject to the requirements listed below.

Claims should be submitted to the appropriate address listed on the Covered Person's identification card, and can be submitted either by the Provider or the Covered Person. Such claim should be on any of the following appropriate forms (or their successor forms):

A. CMS 1500;
B. UB-92;
C. UB-04 or CMS 1450;
D. NCPDP Form 1983; or
E. J512 claim forms.

A Clean Claim can be submitted by the Provider in electronic format if the Provider submits it in accordance with the electronic transaction requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent laws.

In order to be considered a Clean Claim, such claim must use the most current CPT code in effect as published by the American Medical Association, the *International Statistical Classification of Diseases and Related Health Problems* ("ICD") codes, including ICD-9 and ICD-10, published by the World Health Organization, the most current dental code in effect as published by the American Dental Association in the *Code for Dental Procedures or Nomenclature* or the most current HCPCS code in effect, as published by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

If the Plan is not the primary carrier for a Covered Person who has, or had at the time the claim was incurred, more than one health plan that would provide benefits for the services or supplies for which the claim is being made, including, but not limited to Medicare, copies of the explanations of benefit payment from all carriers who would pay benefits before the Plan should be submitted with the claim. For more information regarding which plan pays first, see Section 12.1, or contact the Benefit Manager.

4.2 REQUESTS FOR ADDITIONAL INFORMATION

If the claim is not submitted in accordance with the procedures listed in Section 4.1, the claim will not be considered to be a Clean Claim, and the Participant or Covered Person will be notified of the claim deficiencies, and requested to refile it in the proper format.

If the Plan Administrator or the Benefit Manager needs more information to process the claim, a letter will be sent to the Participant, the Covered Person, the Provider or other parties requesting additional information. In some situations, information is needed on a periodic basis, including:

A. information regarding other coverage. This may include providing copies of medical child support orders for children of divorced parents; and
B. verification of handicapped status for overage Dependent children.

Other information may be requested on a case-by-case basis, including information pertaining to accident details or potential third-party liability.

The requested information must be provided within forty-five (45) days of the date the Participant or Covered Person receives notice of the required additional information. If the information is not received within this time period, the claim will be denied for failure to provide the needed information.

4.3 APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The Covered Person can appeal an Adverse Benefit Determination by the Plan, including that coverage for a service or supply is denied or reduced under the Plan, or any rescission of coverage for an individual or pre-service coverage denials, provided such appeal is made in writing within one hundred eighty (180) days of the Covered Person or Participant's receipt of the explanation of benefit payment or the precertification letter reflecting the denial or reduction or any other notification made by the Plan of an adverse decision involving the individual. Any individual other than the Covered Person who wishes to submit an appeal on the Covered Person's behalf (other than a parent or Legal Guardian filing an appeal for a minor child) must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the appeal. An assignment of benefits is not sufficient to designate another person as an "authorized representative" for the purpose of an appeal. These appeal procedures shall not apply to any contractual Dispute between a Provider and the Plan as to amounts due the Provider, rather than the Covered Person, under the terms of any agreement between the Provider and the Plan that does not affect the amount payable by the Covered Person (i.e. balance billing issues in a Preferred Provider contract).

A request for review in which the Covered Person is requesting an expedited appeal of a pre-service claim as an "urgent care" case, as described in Section 6.1, can be submitted either orally or in writing and can be submitted by a Provider with knowledge of the Covered Person's condition without prior designation by the Covered Person. If a course of treatment has been previously approved by the Plan to be provided over a period of time or for a number of treatments, no reduction or termination of coverage for such treatment (other than termination of the individual's coverage under this Plan) will be made without allowing the Covered Person sufficient advance notification and the opportunity to appeal this termination or reduction.

The appeal request should be addressed as follows (unless the Adverse Benefit Determination notification indicates otherwise):

Plan Administrator
Anderson County Government Employee Benefit Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.
P.O. Box 1099
Newark, Ohio 43058-1099

The writing should clearly be identified as an appeal, and include the name of the Plan, the Covered Person whose claims are the subject of the appeal, the Participant's identification number, and the identity of the specific treatment, service or supply for which coverage was denied or limited under the Plan.

The Covered Person should submit with the appeal written comments, documents, records and other information relating to the claim for benefits, even if such information was not submitted as part of the initial claim or request for preauthorization or precertification. The Covered Person will also have the right to present testimony as part of the appeal.

The Covered Person has the right to request information from the Plan Administrator as part of the appeals process, as described in Section 4.4.

Appeals submitted under this Plan will be adjudicated in a manner designed to ensure the independence and impartiality of the person making the decision. The Plan Administrator has the sole authority for the final decision on all Plan matters, including appeals.

4.4 ACCESS TO DOCUMENTS, RECORDS OR OTHER INFORMATION

A Covered Person is entitled to examine the claim file, and present testimony as part of the internal claims and review process. He or she will also receive, reasonable access to documents, records and other information generated by the Plan Administrator that is relevant to his or her claim for benefits, including any new or additional information received during the appeals process, and the rationale behind the Plan's adverse decision. Such information will be provided within sufficient time to respond prior to the final decision of the appeal by the Plan Administrator. Such information is considered to be relevant if it:

A. was relied upon by the Plan Administrator in making the benefit determination;
B. was submitted, considered or generated in the course of making the benefit determination;
C. demonstrates compliance with the administrative processes required by ERISA;
D. constitutes a statement of policy or guidance with respect to the Plan concerning the denial of a treatment option or benefit; or
E. involves the identity of medical or vocational experts whose advice was obtained in connection with the claim.

In addition, if an Adverse Benefit Determination is based upon the Medical Necessity or Experimental nature of the service or supply, the Covered Person can request an explanation of the scientific or clinical judgment of the determination, free of charge.

4.5 EXTERNAL REVIEW RIGHTS AND PROCEDURES

If the Covered Person is not satisfied with the Plan Administrator's decision on his or her appeal of a medical issue, including issues involving Medical Necessity or the Experimental status of a medical procedure, or any coverage rescission, he or she may file a request for an external review with the Plan Administrator at the address listed above for submitting an appeal. The request must be filed within four (4) months after the date of receipt of the Plan Administrator's determination on his or her appeal. If there is no corresponding date four (4) months after the date of receipt of notice, then the request must be filed by the first (1st) day of the fifth (5th) month following the receipt of the Plan's determination on his or her appeal. The Covered Person can make a request for an expedited review of a precertification denial if the timeframe for completion of a standard review would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function, or if the determination concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received Emergency services, but has not been discharged from a facility. A standard external review would generally be completed within fifty (50) days of the Plan's receipt of the request, while an expedited review must be completed by the independent review organization (IRO) within seventy-two (72) hours of the IRO's receipt of such request. The Plan Administrator will review the request and determine whether or not the request meets the criteria for external review or an expedited review, including whether or not the person was a Covered Person under the Plan at the time the claim arose, whether the person has exhausted the Plan's appeal process, and whether the sufficient information has been submitted to process the external review. A notification will be issued by the Plan Administrator regarding the Covered Person's incomplete request for an external review. If the request is incomplete, the Covered Person will be given additional time to complete the external review request. Once a determination has been made by the Plan Administrator that the request qualifies for external review, it will be forwarded by the Plan Administrator to a qualified IRO. The IRO will notify the Covered Person if the request is accepted for review, and, if a standard review, that he or she can submit additional information that is relevant to the request within ten (10) days of the notification. The IRO may also request additional information from the Covered Person and/or the Plan. Additional information provided by the Covered Person will be provided to the Plan Administrator. If, based on this additional information, the Plan Administrator determines that the initial determination should be reversed, and that coverage should be provided under the Plan, all parties will be notified, and the external review will be closed. Otherwise, after the IRO has completed the review, the Covered Person and the Plan Administrator will be notified

of the IRO's determination. If the IRO determines that coverage under the Plan should have been provided, the Plan will promptly pay any additional benefits deemed due on the Covered Person's behalf. However, either the Plan or the Covered Person has the right to appeal the decision, or utilize any other remedy available under any applicable state or federal law, if either disagrees with the decision of the IRO.

4.6 ADDITIONAL APPEAL RIGHTS

No action at law or in equity shall be brought to recover benefits under the Plan prior to the exhaustion of all claims and appeals procedures described in this Article, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof is required by the Plan.

4.7 EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Injury or illness is the basis of a claim hereunder when and as often as it may reasonably require during the pending claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law.

4.8 PLAN ADMINISTRATOR DISCRETION

Nothing in this Plan precludes the Plan Administrator from exercising full discretionary authority and responsibility with respect to all aspects of Plan administration and interpretation. The Plan Administrator shall have all powers necessary to carry out the purposes of the Plan, including supplying any omissions in accordance with the intent of the Plan and deciding all questions concerning eligibility for participation in the Plan and concerning the amount of benefits payable to a Covered Person.

ARTICLE V
COVERAGE AND ELIGIBILITY

5.1 COVERAGE UNDER THIS PLAN

Coverage provided under the Plan for a Participant shall be in accordance with the Participant Eligibility, Participant Effective Date and Participant Termination provisions included herein.

This Plan includes a two (2) medical options. At the time of enrollment, a Participant must select which option, if any, in which such Participant and/or his or her Dependents should be enrolled. All Family members must be enrolled in the same option. If a Participant wants to change his or her Plan option or enroll in coverage that was previously waived, such Participant, and any Dependents, must wait for the Plan's open enrollment period, as described in Section 5.7, unless he or she has a life changing event, as described in Section 5.6.

5.2 PARTICIPANT ELIGIBILITY

Only Individuals who meet all of the conditions of one (1) of the following categories shall be deemed eligible for coverage as a Participant under the Plan:

A. an employee who:
   1. is expected by the Employer as of the date of his or her hire to be a Full-Time Employee; and
   2. has satisfied a thirty (30) day Waiting Period, commencing with his or her date of hire. If an employee is employed by all or part of this thirty (30) day Waiting Period and is absent from work due to any health factor (such as being absent from work on sick leave) the employee will be considered Actively At Work for the period of his or her absence upon his return to work. This Waiting Period may be waived, in whole or in part, if:
      a. during the first twelve (12) months of his or her employment, coverage is terminated because he or she is no longer a Full-Time Employee, coverage will be reinstated on the first of any month in which the employee is once again employed for at least one hundred thirty (130) hours, provided that a period of more than thirteen (13) weeks has not expired during which the employee was credited with no hours of employment with the Employer; or
      b. an employee is employed by the Employer for any or all of this thirty (30) day waiting period prior to his or her entry into Service in the Uniformed Services, this period of previous employment shall be credited towards the partial or full satisfaction of any waiting period imposed under this Plan if the employee is re-employed by the Employer at the expiration of the term of Service in the Uniformed Services, provided such employee applies for reemployment within the applicable time frame listed in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as described in Section 5.11; or

B. if not eligible under A above, is a Variable Hour Employee or an On-Going Employee of the Employer, for whom it has been determined during the most recent applicable Measurement Period to have worked an average of at least thirty (30) hours per week during such Measurement Period. Coverage for such employee will become effective (or be continued) as of the first day of the next applicable Stability Period, as long as such employee is still employed on that date.

   A new Variable Hour Employee, or an On-Going Employee who was not previously eligible who has a Change in Employment Status during a Measurement Period, will be treated as a Full-Time Employee as of the earlier of:
   1. thirty (30) days following the Change in Employment Status; or

2. the first day of the next Stability Period applicable to such person (provided the employee averaged more than thirty (30) hours of service per week during the prior applicable Measurement Period).

For purposes of this Plan, Change in Employment Status means a material change in the employee's position of employment or other employment status that, had the employee begun employment in the new position or status, the employee would have reasonably been expected to work thirty (30) or more hours of service per week;

C. is a County Commissioner who has satisfied a thirty (30) day Waiting Period, commencing with the first day of the term of office following the date he or she was elected to the County Commission. This Waiting Period may be waived in whole or in part under the circumstances described under Section A.2 above; or

D. is a Retiree, as defined in Section 3.1.

Participants must agree to any applicable Participant Contribution for such coverage.

5.3 DEPENDENT COVERAGES

A Participant eligible to elect Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent, as defined in Section 3.1. A Dependent of a Retiree must have enrolled prior to the date of the retirement in order to be eligible under the Plan. A Participant must make written request for Dependent Coverage and agree to any applicable Participant Contribution for such coverage. Each Participant will become eligible to elect Dependent Coverage on the latest of the following:

A. the date he or she becomes eligible for Participant coverage; or

B. the date on which he or she first acquires a Dependent.

If two (2) spouses are employed by the County, and both are eligible to elect Dependent coverage, one (1) spouse or the other, but not both, may elect Dependent Coverage for the eligible Dependents. In addition, no person can be covered under this Plan as both a Participant and a Dependent, or the Dependent of more than one (1) Participant.

5.4 PARTICIPANT EFFECTIVE DATE

Each eligible employee who makes written request for Participant coverage hereunder, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become effective on the first of the month following the date he or she becomes eligible, provided the written application for such coverage is made within thirty (30) days of the date he or she becomes eligible for Participant Coverage.

Any eligible person, other than a Retiree, who wishes to make an application for Participant coverage other than as described above, or as described in Section 5.6, shall be required to wait until the next Plan open enrollment period, as described in Section 5.7 before such application can be submitted. A Retiree must be enrolled in this Plan on the date of retirement, and cannot apply, or re-apply, for coverage after such date.

5.5 DEPENDENT EFFECTIVE DATE

Each Participant who makes written request for Dependent Coverage hereunder within the thirty (30) day period immediately following the first day on which he or she is eligible for Dependent Coverage or when a life changing event, as described in Section 5.6, applies to such Dependent, on a form approved by the Plan Administrator, subject to the provisions of this section and who agrees to the applicable Participant Contribution for such coverage, shall become eligible for Dependent Coverage on the later of the date specified in the life changing event period or the date the Participant becomes covered, as applicable.

Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.6, shall be required to wait until the next Plan open enrollment

period, as described in Section 5.7 before such application can be submitted. A Dependent of a Retiree must have enrolled prior to the date of the retirement in order to be eligible under the Plan.

5.6 LIFE CHANGING EVENT PERIODS

An eligible person for whom written application for coverage is submitted under any of the circumstances listed below will be eligible for coverage on the date specified below:

A. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the date of a Dependent child's birth. The eligible employee, the Newborn, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this life changing event period. Coverage shall become effective on the date of the Dependent child's birth;

B. within thirty (30) days *(sixty (60) days effective 10/1/2019)* after the adoption of a Dependent child, or the Placement for Adoption with the employee of such a child. The eligible employee, the newly acquired Dependent child, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this life changing event period. Coverage shall become effective on the date of the adoption or Placement for Adoption;

C. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the date of the eligible employee's marriage. The eligible employee, the new Dependent spouse, and any other eligible Dependent children who are eligible as a result of the marriage are eligible to enroll during this life changing event period. Coverage shall become effective on the date of the marriage;

D. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the entry of an order requiring the employee to provide medical coverage for a Dependent child. The eligible employee, the Dependent child or children who are the subject of the court order, the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this life changing event period. Coverage shall become effective on the date of the court order;

E. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the date a Dependent child otherwise first becomes eligible, or re-eligible for coverage after a period of ineligibility. The employee must already be enrolled as a Participant. The employee, the newly acquired Dependent child, the Dependent spouse, and any other eligible Dependent children shall be eligible to enroll during this life changing event period. Coverage shall become effective on the date the child becomes eligible/re-eligible for coverage;

F. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the date the employee experiences a "change in family status" under the Employer's Section 125/cafeteria plan. Only the family members who are affected by the "change in family status" are eligible to enroll during this life changing event period. Coverage shall become effective on the date the change becomes effective under the Section 125/cafeteria plan;

G. within sixty (60) days of the date an eligible employee and/or his or her Dependent(s) first become eligible for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), or, if covered, becomes ineligible for coverage through such programs. The eligible employee, any eligible Family member who becomes eligible or loses eligibility through such programs , the Dependent spouse, and any other eligible Dependent children are eligible to enroll during this life changing event period. Coverage shall become effective on the date of eligibility/ineligibility; or

H. within thirty (30) days *(sixty (60) days effective 10/1/2019)* of the date coverage under another group health plan or health insurance coverage was lost, if:

   1. the reason the eligible employee and/or Dependent did not enroll for coverage under this Plan when initially eligible was the existence of the other coverage; and
   2. the person lost coverage under the other plan due to one (1) of the following:

a. if covered under a COBRA continuation provision, the exhaustion of COBRA continuation coverage under the other plan;
b. the loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment or other involuntary loss of eligibility (with the exception of terminations due to fraud or failure to pay premiums);
c. the overall lifetime maximum benefit under the other coverage has been exhausted so that no further expenses will be payable under such coverage; or
d. the termination of employer contributions towards such other coverage.

Coverage for which a person is eligible under this provision shall become effective on the day following the date coverage under the prior plan is terminated.

In no event shall any person become covered under this Plan prior to the date the Participant becomes a Covered Person, or prior to the end of the waiting period listed in Section 5.2. Covered Persons can also change coverage options or voluntarily terminate coverage pursuant to a life changing event. The above provisions do not apply to Retirees when it comes to adding a Dependent(s) to his or her Plan; however, Retirees and their covered Dependents are permitted to terminate coverage during a life changing event.

5.7 OPEN ENROLLMENT

The Plan will have an annual open enrollment period during which otherwise eligible persons who were not enrolled when initially eligible (or who previously terminated coverage) and do not qualify for one of the life changing event periods described in Section 5.6 can be enrolled in the Plan. Additionally, Covered Persons can change Plan options or voluntarily terminate from coverage at this time. This provision does not apply to Retirees. Applications submitted pursuant to this open enrollment provision must be submitted during the month of May each year. Coverage for any person for whom application for coverage under this Plan was submitted pursuant to this provision shall be effective July 1st of the same year.

5.8 PARTICIPANT TERMINATION

Participant coverage terminates immediately upon the earliest of the following dates:

A. if covered under the provisions of Section 5.2 A above as a regular, Full-Time Employee, the last day of the month in which the Participant is no longer paid for working the number of hours required for Full-Time Employee status, or otherwise fails to meet the eligibility requirements listed in Section 5.2;
B. if covered under the provisions of Section 5.2 B as a Variable Hour Employee or an On-Going Employee, the earlier of the last day of the last Stability Period during which the employee was eligible if the employee failed to average thirty (30) hours per week during the latest Measurement Period that applies to such employee, or the end of the month following the date such employee's employment with the Employer is terminated. This will be considered to be a reduction in hours Qualifying Event for the purposes of this Plan's COBRA continuation provisions;
C. if covered under the provisions of Section 5.2 C as a County Commissioner, the last day of the month in which his or her elected term of office ends;
D. if covered under the provisions of Section 5.2 D as a Retiree, the last day of the month in which the retired individual no longer meets the requirements of a Retiree, as defined in Article III. Retirees can voluntarily terminate coverage at any time, upon request, in which case, such coverage will end on the date the coverage is terminated;
E. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Participant, including, but not limited to, intentionally submitting false claims to the Plan,

or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;

F. the last day of the month for which a Participant Contribution was made following the date the Participant fails to make any required Participant Contribution for coverage, unless such Participant is continuing coverage under FMLA; or

G. the date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of any such benefit.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 5.10, and COBRA continuation coverage as described in Article VII. This Plan will also comply with the continuation provisions contained in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as they apply to Participants entering Service in the Uniformed Services, as described in Section 5.11.

5.9 DEPENDENT TERMINATION

Dependent Coverage terminates immediately upon the earliest of the following dates:

A. the date the Participant's coverage ceases under this Plan;

B. the date the Retiree's coverage ceases under this Plan;

C. if a Dependent is no longer eligible for coverage due to divorce or other instance contingent upon a court order such as loss of Legal Guardianship, the date of the divorce or court order;

D. otherwise the last day of the month in which the Dependent ceases to be a Dependent, as defined in Article III;

E. the date specified in the notification from the Plan Administrator that coverage is terminated due to fraud or a material fraudulent act committed or contributed to by the Dependent, including, but not limited to, intentionally submitting false claims to the Plan, or knowingly allowing the use of a Plan identification card to obtain Plan benefits by a person who is not authorized to do so;

F. the last day of the month for which a Participant Contribution for Dependent Coverage was made following the date the Participant fails to make any required Participant Contribution for Dependent Coverage; or

G. the date of cancellation of Dependent benefits under this Plan.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the COBRA continuation coverage as described in Article VII.

5.10 FAMILY AND MEDICAL LEAVE PROVISIONS

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of health benefits during any period that an eligible employee takes a leave of absence in accordance with the Employer's FMLA policy, if the Employer is subject to such law. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the Employer and employees concerning conditions of leave, and notification and reporting requirements are specified in the Employer's FMLA policy. If the Employer is subject to FMLA, any Plan provision that conflicts with FMLA is superseded by FMLA to the extent such provision conflicts with FMLA. Questions regarding rights and/or obligations under FMLA should be directed to an Employer representative or the Plan Administrator.

5.11 USERRA RIGHTS

A Participant under this Plan who is no longer Actively At Work due to his or her Service in the Uniformed Services can elect, under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to continue Participant and Dependent Coverage under this Plan for up to twenty-four (24) months after such coverage would otherwise have terminated. This period of continued coverage shall run concurrently with any continuation for which any Covered Person would have been entitled to under the provisions of COBRA due to the Participant's termination or reduction in hours of employment. If the Service in the Uniformed Services is for thirty-one (31) days or more, the Participant Contribution for such coverage will be one hundred two percent (102%) of the full cost of the coverage, without any Employer contribution. If the Service in the Uniformed Services is less than thirty-one (31) days, the Participant Contribution shall be the same as would have applied if the Participant were still an active employee.

If coverage is not continued as described above, or the Service in the Uniformed Services exceeds the time limit listed above, upon release from his or her Service in the Uniformed Services, coverage will be reinstated in the Plan effective the date the employee is reemployed by the Employer, provided the employees reapplies for employment or reports back to work within the following applicable time:

A. if the period of service was less than thirty-one (31) days, the beginning of the next regularly scheduled work period on the first full day after release from Service in the Uniformed Services, taking into account safe travel home plus an eight (8) hour rest period;

B. if the period of service was more than thirty (30) days, but less than one hundred eighty-one (181) days, within fourteen (14) days of release from Service in the Uniformed Services; and

C. if the period of service was more than one hundred eighty (180) days, but less than five (5) years, within ninety (90) days of the release from Service in the Uniformed Services.

This period may be extended for up to two (2) years from the date the Service in the Uniformed Services ended, under the provisions of USERRA, if the person is unable to return to active employment due to a disability incurred while performing Service in the Uniformed Services.

The Plan Administrator reserves the right to request verification of any Service in the Uniformed Services, including copies of military orders or the applicable Form DD 214.

ARTICLE VI
COST MANAGEMENT SERVICES

6.1 UTILIZATION REVIEW

Through September 30, 2019:

The Plan has a utilization pre-certification provision. Pre-admission certification must be obtained for every Inpatient admission to a covered facility, including, but not limited to Hospitals, Skilled Nursing Facilities, Hospices, psychiatric treatment facilities and Alcoholism and Substance Abuse treatment facilities, except Emergency admissions, Urgent Care admissions, and minimum stays following childbirth. ("Emergency" and "Urgent Care" admissions are defined below). A "minimum stay following childbirth" is either:

A. a stay following a normal vaginal delivery that is forty-eight (48) hours or less; or
B. a stay following a cesarean section that is ninety-six (96) hours or less.

If a Hospital stay following childbirth will exceed the limitations listed above, the Pre-Certification Center must be notified as soon as the Covered Person and/or her Provider have determined that the hospitalization will exceed such limitations, but not later than the end of the applicable period listed above.

Pre-admission certification may be made through the Utilization Review Service. The telephone number for the Utilization Review Service is listed in Article I, Plan Information, and on the medical identification card. A Covered Person may inform his or her health care Provider that he or she participates in a program that has pre-admission certification provisions. In order to obtain pre-admission certification:

A. contact the Utilization Review Service and report the upcoming Hospital or other facility stay no later than forty-eight (48) hours prior to the admission;
B. notice can be given by:
    1. the Hospital or other covered facility;
    2. the Covered Person's admitting Physician;
    3. the Covered Person;
    4. a family member of the Covered Person; or
    5. a representative of the Employer; and
C. the Utilization Review Service must be provided with information necessary to make a decision as to the Medical Necessity of the admission.

Effective October 1, 2019:

Pre-certification certification through the Utilization Review Service is required for the following Inpatient services and supplies.

Admissions in which pre-certification is required include:

A. any long-term acute care;
B. other acute care;
C. routine maternity that exceeds the federal requirements and high-risk maternity;
D. Skilled Nursing Facilities;
E. rehabilitation services;
F. detoxification; and
G. Inpatient confinements for mental health and substance abuse treatment in a Hospital or Residential Treatment Facility.

All services and supplies described in this Section 6.1 are subject to the definition of Experimental or Investigative, as described in Article III of the Plan.

The Utilization Review Service may request additional information that is necessary to make the determination from the Covered Person or a Provider. In the case of an urgent care request, such information must be provided within forty-eight (48) hours of the request. A decision will be made as soon as reasonably possible, but not later than seventy-two (72) hours of the Plan's receipt of all information necessary to make the determination. If the request does not involve urgent care, the information must be provided within forty-five (45) days of such request. An "urgent care" request is one that, if a determination is not made on an expedited basis, the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function, could be seriously jeopardized, or, in the opinion of the attending Physician, the Covered Person would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

When pre-admission certification is provided to the Covered Person, a certain number of Inpatient days for the stay will be assigned. If the Utilization Review Service is not informed of the Covered Person's admission within the required timeframe, there will be a penalty. Covered Expenses for Hospital or other facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, would have approved for payment under the Pre-Admission Certification program will be reduced by twenty percent (20%) up to a maximum of five hundred dollars ($500.00). (This reduction is the penalty). The penalty will be figured before the Deductible and Coinsurance are applied. The penalty is not considered an eligible expense. Charges for Inpatient days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

6.2 CONTINUED STAY REVIEW

During a Covered Person's Inpatient stay, a Continued Stay Review will be conducted. This review applies to all Hospital or other facility admissions. The purpose of Continued Stay Review is to:

A. provide the Utilization Review Service with an update as to the Covered Person's condition and/or progress; and

B. if necessary, enable the Utilization Review Service to re-evaluate the Medical Necessity of a continued Inpatient stay.

The Utilization Review Service has the right to initiate a Continued Stay Review for any Inpatient admission. The, Utilization Review Service will always confirm the outcome of the Continued Stay Review by telephone or in writing. This notification will go to the Covered Person and/or the Covered Person's Physician. The notification always includes any newly authorized length of stay.

If a stay is longer than the specified number of Inpatient days that the Utilization Review Service considers to be Medically Necessary, Covered Expenses will be denied for any charges incurred for the days not Medically Necessary. This will occur if the Utilization Review Service is informed that the confinement is no longer Medically Necessary and the Covered Person knowingly chooses to remain in the Hospital or other facility.

If the Covered Person's Physician and the Covered Person disagree with the findings of the Utilization Review Service, the Covered Person may file an appeal, in accordance with the procedures described in Article IV, with the Plan Administrator. The Plan Administrator has final authority over any such decisions.

6.3 WEEKEND ADMISSION REVIEW

All weekend (Friday, Saturday, and Sunday) Hospital admissions will be reviewed. Coverage is limited to Medically Necessary admissions.

6.4 EMERGENCY AND URGENT CARE REVIEW

If a Covered Person is admitted to a Hospital or other covered facility for an Emergency or Urgent Care admission, notice of the admission may be provided to the Utilization Review Service no later than forty-eight (48) hours after the admission or as soon as reasonably possible. Notice may be given to the Utilization Review Service by:

A. the Hospital or other facility;
B. the Covered Person's admitting Physician;
C. the Covered Person;
D. a family member of the Covered Person; or
E. a representative of the Employer.

The Utilization Review Service will review the case with the Covered Person's Physician to determine if a continued Inpatient stay is Medically Necessary. If the Utilization Review Service is not informed of the Covered Person's admission, there will be a penalty. Covered Expenses for Hospital or other facility services the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, would have approved for payment under the Pre-Admission Certification program will be reduced by twenty percent (20%) up to a maximum of five hundred dollars ($500.00). (This reduction is the penalty). The penalty will be figured before the Deductible and Coinsurance are applied. The penalty is not considered an eligible expense. Charges for Inpatient days that are determined by the Utilization Review Service to not be Medically Necessary are not covered under this Plan.

An Emergency admission is an admission to a Hospital through the emergency room of that facility for treatment of a life-threatening illness or Injury. An Urgent Care admission is an unplanned admission or an admission scheduled less than forty-eight (48) hours prior, for a condition requiring prompt medical attention. An Urgent Care admission is not an admission through the emergency room.

In the case of Emergency or Urgent Care Outpatient surgical procedures, it is recommended that notification be provided to the Utilization Review Service no later than forty-eight (48) hours after the surgical procedure or as soon as reasonably possible. The penalty described above will not apply for failure to make such notification.

6.5 DISCHARGE PLANNING

Review for Discharge Planning occurs during hospitalization review. The purpose is to:

A. identify patients requiring extended care following discharge; and
B. determine the most appropriate setting for continued care.

6.6 PRE-CERTIFICATION OF CERTAIN OUTPATIENT SERVICES

Through September 30, 2019:

The Plan requires that all non-office based Outpatient surgery, skilled nursing care provided in the home, transplant services and Proton Beam Therapy be pre-approved by the Utilization Review Service prior to any such procedure or service. As soon as possible after a Covered Person's Physician has determined that a procedure or service is necessary, but not later than forty-eight (48) hours prior to the procedure or service, the Covered Person's Physician, the Covered Person or the Hospital or facility where the procedure or service is to be performed must notify the Utilization Review Service and submit any documentation required by such Utilization Review Service. The Covered Person is ultimately responsible for making sure this notification is made. The Utilization Review Service reserves the right to request additional records or information from the Covered Person, the Covered Person's Physician, Hospital or other facility or Provider that is related to the procedure or service.

Effective October 1, 2019:

Pre-certification is required for Outpatient treatment involving any of the following conditions or procedures:

A. home health care, including a registered nurse, licensed practical nurse or home health aide in the home;
B. home infusion therapy for:
    1. immunotherapy;
    2. continuous medications;
    3. hydration;
    4. total parenteral nutrition; and
    5. pain management;
C. oral pharynx procedures, including;
    1. uvulectomy;
    2. LAUP procedures;
    3. palatopharyngoplasty (PPP); and
    4. uvulopalatopharyngoplasty (UPP);
D. other Outpatient procedures, including;
    1. facial reconstruction;
    2. varicose vein treatment;
    3. breast reconstruction or reduction;
    4. blepharoplasty; and
    5. rhinoplasty;
E. spinal procedures, including;
    1. allograft/osteopromotive material for spine Surgery;
    2. osteotomy;
    3. percutaneous vertebroplasty;
    4. arthrodesis, laminectomy;
    5. vertebral corpectomy;
    6. destruction by neurolytic agent;
    7. laminotomy;
    8. facet joint nerve destruction; and
    9. spinal cord decompression;
F. therapeutic radiology, including;
    1. brachytherapy;
    2. Proton Beam Therapy; and
    3. radiotherapy;
G. transplants, including;
    1. adult or pediatric;
    2. living or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; and
    3. preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants; and transplant-related travel and lodging.

If prior approval is not obtained for any of these services or procedures, charges for such service will be subject to a penalty. Expenses for services or supplies that would have been approved for

payment by the Utilization Review Service, as the entity designated by the Plan Administrator to handle utilization review, will be reduced by twenty percent (20%) up to a maximum of five hundred dollars ($500.00), per service or per course of treatment for Proton Beam Therapy. (This reduction is the penalty). The penalty will be figured before the Deductible and Coinsurance are applied. This penalty will not be considered as a Covered Expense under any other Plan provision, and shall not apply towards any Deductible, Out-of-Pocket limit, or maximum benefit limit. In addition to this penalty, any services and supplies that would not have been approved for payment will not be covered under this Plan.

6.7 INDIVIDUAL BENEFITS MANAGEMENT

Individual benefits management is designed to inform Covered Persons of more cost effective settings for treatment. On an exception basis and subject to approval, the Plan may provide benefits for settings not expressly provided for under this Plan, but which are not prohibited by law, rule or federal policy.

Services and Supplies provided in connection with individual benefits management must be:

A. for an acute level of care;
B. Medically Necessary; and
C. provided in a more cost effective setting.

Under individual benefits management, the Plan Administrator may waive the Deductible or Coinsurance amount for certain services.

The Plan Administrator has the right to deny an extension of benefits under individual benefits management. The Plan Administrator also has the right to administer benefits pursuant to the terms of the Plan, exclusive of this provision. If benefits are provided to a Covered Person, under this provision for individual benefits management, that are outside of the conditions, limitations and/or exclusions of this Plan, the Covered Person has no right to expect that the same or similar benefits (provided outside of the conditions, limitations and/or exclusions of this Plan) will be provided to that Covered Person in the future.

The Plan Administrator shall have full discretionary authority and responsibility with respect to all aspects of Plan administration, including utilization review. If a Utilization Review Service is designated by the Plan Administrator, the Utilization Review Service agrees to recognize the ultimate authority of the Plan Administrator.

6.8 SECOND SURGICAL OPINION

The Plan will provide benefits for a second surgical opinion, including necessary testing, prior to any elective surgery.

The Physician providing the second surgical opinion must be qualified to render such an opinion, through experience or training, in the field related to the surgical procedure, and must not be financially associated with the Physician who recommended and/or will perform the Surgery.

The Plan Administrator and the Utilization Review Service reserve the right to direct the Covered Person to a Physician of their choosing for a second surgical opinion.

ARTICLE VII
CONTINUATION COVERAGE UNDER COBRA

7.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the County. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

A. the date of the Qualifying Event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss that qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible.

7.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the County of the Qualifying Event within sixty (60) days of the event, or sixty (60) days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the County in accordance with the section below entitled "Total Disability" in order for coverage to continue.

7.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage may continue coverage under the Group Health Plan for:

A. a Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee:
    1. for up to eighteen (18) months from the date of the Qualifying Event; or
    2. if a Qualified Beneficiary is Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to twenty-nine (29) months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the County of the determination of his or her Total Disability under the Social Security Act:
        a. before the end of the original eighteen (18) month continuation period; and
        b. within sixty (60) days following the date of such determination; or

B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or Medicare eligibility and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

7.4 TERMINATION OF CONTINUATION OF COVERAGE

Continuation Coverage will automatically end earlier than the applicable eighteen (18) or thirty-six (36) month period for a Qualified Beneficiary if:

A. the required monthly contribution for coverage is not received by the Benefit Manager within thirty (30) days following the date it is due;
B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the pre-existing condition applies to the Qualified Beneficiary;
C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;
D. the Qualified Beneficiary becomes entitled to Medicare benefits; or
E. the County ceases to offer any Group Health Plans.

7.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) months, and a second Qualifying Event occurs during the eighteen (18) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

7.6 TOTAL DISABILITY

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

A. prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and
B. within sixty (60) days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification.

The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months nineteen (19) through twenty-nine (29)) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

A. the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
B. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

7.7 CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and Copayment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

7.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, that will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.

For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months nineteen (19) through twenty-nine (29).

Contributions for coverage may, at the election of the payer, be paid in monthly installments.

If Continuation Coverage is elected, the first monthly contribution for coverage must be made within forty-five (45) days of the date of election.

Without further notice from the Benefit Manager, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the County within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

7.9 DEFINITIONS

For purposes of this Article VII, unless specifically stated otherwise, the following definitions apply:

A. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

C. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.

D. "County" means the Employer, as defined in Article III.

E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.

F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.

G. "Qualified Beneficiary" means:

   1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and

   2. a covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.

H. "Qualifying Event" means the following events that, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:

1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;
2. the death of the Covered Employee;
3. the divorce or legal separation of the Covered Employee from his or her spouse;
4. the Covered Employee becoming entitled to Medicare coverage; or
5. a child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.

I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

7.10 COBRA BANKRUPTCY PROVISIONS UNDER TITLE XI

For purposes of this subsection only:

A. "Qualified Beneficiary" means:
   1. a Covered Employee who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Group Health Plan;
   2. an individual who was covered under the Group Health Plan as a surviving spouse of a deceased retiree on the day before the date of the Qualifying Event; and
   3. a Dependent of either of the above described individuals who was covered under the Group Health Plan on the day before the date of the Qualifying Event.

B. "Qualifying Event" means the substantial elimination of coverage under the Group Health Plan within one (1) year before or after the County files a petition in bankruptcy under Title XI of the United States Code.

If a Qualified Beneficiary experiences a Qualifying Event, as defined in this provision, he or she may elect to continue coverage under the Group Health Plan if he or she pays the monthly contribution specified from time to time by the County and makes his or her election in accordance with the provision above entitled "Right to Elect Continuation Coverage."

Continuation Coverage for a Qualified Beneficiary who is a retiree and his or her Dependents who are Qualified Beneficiaries will continue for the life of the retiree. When the retiree dies, his or her Qualified Beneficiaries may elect to continue coverage for up to thirty-six (36) additional months.

If a surviving spouse and Dependent children are covered as beneficiaries of a deceased retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving spouse. Upon the death of the surviving spouse, the Continuation Coverage terminates.

Continuation Coverage elected under this provision will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the County ceases to offer any Group Health Plans.

ARTICLE VIII
MAJOR MEDICAL EXPENSE BENEFITS

8.1 COINSURANCE PERCENTAGE AND DEDUCTIBLE

Each Covered Person must pay the Deductible amount stated in Section 2.3, or the Copayment amount stated in Section 2.4, as applicable, before the Plan begins paying benefits. The Plan will pay the Coinsurance percentage stated in Section 2.5 to the limits shown.

The Deductible applies to Covered Expenses for each Calendar Year. The Deductible will be applied as explained in the definition of Deductible set forth in Article III. Amounts paid to satisfy any individual Deductible during the last three (3) months of a Calendar Year will be applied toward the satisfaction of the individual Deductible for the next Calendar Year on claims Incurred once this Plan is in effect. Any portion of the individual Deductible carried over from the previous Calendar Year will not apply toward the family Deductible, or to the Out-of-Pocket limits in the current Calendar Year.

8.2 ALLOCATION AND APPORTIONMENT OF BENEFITS

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

Many times claims for Covered Expenses are not submitted in the same order in which they were incurred. Regardless of the order in which the claims were Incurred, the Copayments, Deductible and Coinsurance will be applied to Covered Expenses in the sequence that the claims were submitted and ready for payment. Eligibility for any Deductible carryover, however, will be based on the date the expense was incurred.

ARTICLE IX
DESCRIPTION OF BENEFITS

9.1 MEDICAL BENEFITS – COVERED EXPENSES

In order to be eligible for benefits under this section of the Plan, charges actually Incurred by a Covered Person must be for services or supplies administered or ordered by a Physician, be provided by a properly licensed or certified health care professional or entity, and be Medically Necessary and Medically Appropriate for the diagnosis and treatment of an illness or injury unless otherwise specifically covered. In addition, such charges will only be covered to the extent that they do not exceed the Reasonable and Customary charge for the service or supply in question.

Covered charges include the following:

A. Charges for services provided in a Physician's office, including, but not limited to:
   1. diagnosis and treatment of an illness or injury;
   2. injections and the administration of such injections, not including Specialty Drugs;
   3. office-based Surgery;
   4. medical supplies and other services provided in the office;
   5. second surgical opinions; and
   6. Telehealth visits.

B. Charges for the following routine services, subject to the limitation listed in Section 2.8:
   1. services included in the Recommended Wellness Services, as defined in Section 3.1;
   2. routine prostate examinations and testing;
   3. mammography; and
   4. hearing and eye examinations and/or visual acuity screenings.

C. Charges for injections, including, but not limited to:
   1. allergy injections, including the serum/venom;
   2. B12 and iron injections when determined to be Medically Necessary to treat a medical condition beyond vitamin deficiency, such as pernicious anemia;
   3. Medically Necessary testosterone injections. Low testosterone "Low-T" due to aging is not considered Medically Necessary; and
   4. spinal pain injections, subject to the limitations listed in Section 2.8.

   Specialty drugs are not covered under the medical provisions of the Plan.

D. Charges for the following Inpatient Hospital Services and supplies:
   1. Room and Board, subject to the provisions stated in Sections 2.6 and 2.7, general nursing care, medications, injections, diagnostic services and special/intensive care units;
   2. attending Physician's services for professional care; and
   3. Ancillary Services.

E. Charges for maternity and delivery services, including routine nursery care, Newborn male circumcisions and Complications of Pregnancy. Covered services also include breast feeding equipment, support and supplies and lactation counseling, subject to the limitations listed in Section 2.8. If the Hospital or Physician provides services to the baby and submits a claim in the baby's name, benefits will be covered for the baby and mother separately, requiring payment of separate Deductible and Copayments.

All Inpatient confinements are subject to the pre-certification requirements listed in Article VI.

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

The following are not covered:

1. Inpatient stays primarily for therapy (such as physical or occupational therapy);
2. services that could be provided in a less intensive setting; or
3. blood or plasma that is provided at no charge to the Covered Person.

F. Charges for health care services and supplies furnished in a Hospital emergency department. Covered Expenses include:

1. services, supplies and medications that are necessary for the diagnosis and stabilization for the Covered Person's medical condition; and
2. Physician services.

G. Charges for ground or air transportation, services, supplies and medications by a licensed ambulance service when time or technical expertise of the transportation is essential to reduce the probability of harm to the Covered Person. Covered Expenses include:

1. air transportation from the scene of an accident or Emergency to the nearest appropriate Hospital. Air transportation is covered only when the Covered Person's condition requires immediate and rapid transport that cannot be provided by ground transport; and
2. ground transportation:
    a. from the scene of an accident or Emergency to the nearest appropriate Hospital;
    b. treatment at the scene (paramedic services) without ambulance transportation; and
    c. basic or advanced life support when Medically Necessary due to the Covered Person's medical condition.

Transportation for the convenience of the Covered Person, Family members and/or the Covered Person's Physician/other Provider and transportation that is not essential to reduce the probability of harm to the Covered Person are not covered.

H. Charges for the diagnostics, therapies and Surgery occurring in an Outpatient facility that includes Outpatient Surgery centers, the Outpatient center of a Hospital, Outpatient diagnostic centers and certain surgical suites in a Physician's office. Covered Expenses include:

1. Physician services;
2. Outpatient diagnostics (such as x-rays and laboratory services);
3. Outpatient treatments (such as medications and injections);
4. Outpatient Surgery, subject to the pre-certification requirements described in Article VI, and supplies;
5. observation stays of less than twenty-four (24) hours; and
6. Telehealth visits.

Services that could be provided in a less intensive setting are not covered.

I. Charges for family planning services and those services to diagnose and treat diseases that adversely affect fertility. Covered services include:
   1. family planning, history, physical examination, diagnostic testing and Medically Necessary genetic testing with a prior authorization recommended;
   2. sterilization procedures for the Participant, the spouse of the Participant and any Dependent females;
   3. services, supplies and testing in order to diagnose infertility. Corrections of defects preventing Pregnancy are also covered;
   4. elective abortions when the Physician certifies in writing that the mother's life is endangered, the fetus is not viable, the Pregnancy is the result of rape or incest or if the fetus has been diagnosed with a lethal or otherwise significant abnormality; and
   5. FDA approved contraceptive implants, injections, devices, vaginal barrier methods and oral contraception related medical services.

J. Charges for Surgical Procedures intended to restore normal form of function, including:
   1. Surgery to correct significant defects from congenital causes (except where specifically excluded), accidents or disfigurement from a disease state; and
   2. breast reconstruction in connection with a mastectomy, including:
      a. reconstruction of the breast on which the mastectomy was performed;
      b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
      c. prostheses and physical complications of all stages of mastectomy, including lymphedemas.

      Such reconstruction must be performed in a manner determined in consultation with the attending Physician and the Covered Person.

   Outpatient Surgical Procedures are subject to the pre-certification requirements described in Article VI. Covered Expenses, including both Physician and facility expenses, for robotic surgical procedures and related expenses will be limited to the Reasonable and Customary charge for the same surgical procedure performed under standard methods. Multiple Surgical Procedures are covered as described in Article III.

K. Charges for Medically Necessary services and supplies in a skilled nursing/extended care facility, subject to the limitations listed in Section 2.8. Covered services include:
   1. Room and Board in a Semi-Private room, general nursing care, medications, diagnostics and intensive/special care units; and
   2. the attending Physician's services for professional care.

   Confinements in an extended care/skilled nursing facility are subject to the pre-certification requirements described in Article VI.

L. Charges for therapeutic, habilitative and rehabilitative services performed in a Physician's office, Outpatient facility or home health setting and that are intended to restore or improve bodily function. Covered services include:
   1. Outpatient, home health or office services that are expected to result in significant and measurable improvement in the Covered Person's condition, subject to the limitations listed in Section 2.8. The services must be performed by, or under the direct supervision of a licensed therapist, upon written authorization of the treating Physician; and

2. therapeutic, habilitative and rehabilitative services, subject to the limitations listed in Section 2.8, including:
    a. physical therapy, including aquatic therapy (hydrotherapy);
    b. speech therapy;
    c. occupational therapy;
    d. manipulative therapy; and
    e. cardiac and pulmonary therapy services.

The following are not covered under the Plan:

1. treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing Maintenance or palliative care;
2. complementary and alternative therapeutic services, including, but not limited to:
    a. massage therapy;
    b. acupuncture;
    c. craniosacral therapy; and
    d. vision exercise therapy;
3. modalities that do not require the attendance or supervision of a licensed therapist, including but not limited to:
    a. activities that are primarily social or recreational in nature;
    b. simple exercise programs;
    c. hot and cold packs applied in the absence of associated therapy modalities;
    d. repetitive exercises or tasks that the Covered Person can perform in a home setting without a therapist;
    e. routine dressing changes; and
    f. custodial services that can ordinarily be taught to the Covered Person or the caregiver;
4. behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions as part of speech therapy, physical therapy or occupational therapy programs, unless specifically listed elsewhere as covered; or
5. duplicate therapy. For example, when the Covered Person receives both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

M. Charges for non-Experimental or non-Investigational organ and tissue transplant services, subject to the pre-certification requirements listed in Article VI. Coverage is provided for the transplant recipient and donor charges. Donor charges are covered only if the recipient is covered under this Plan. If the organ donor is covered under this Plan and suffers complications, side effects or injuries as a result of such organ donation, charges will be covered under the donor's benefits and treated as any other illness. This Plan has an agreement with a special transplant network that can provide transplant related services to Covered Persons under this Plan at a cost that is less, for the most part, than that charged to other patients of the facility. For more information about accessing this network, contact the Benefit Manager or Utilization Review Service. If the special transplant network is utilized, Covered Expenses will also include travel, transportation, meals and lodging, subject to the limitations listed in Section 2.8.

The following transplant related services are not covered:

1. transplant and related services, including donor services, that did not meet the pre-certification requirements described in Article VI;
2. any attempted covered procedure that was not performed, except where such failure is beyond the Covered Person's control;
3. services that are specifically listed as excluded;
4. services that would be covered by a private or public research fund, regardless of whether the Covered Person applied for or received amounts from such fund;
5. any non-human, artificial or mechanical organ not determined to be Medically Necessary;
6. payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
7. donor charges, including complications, for a transplant in which the recipient is not covered under this Plan;
8. harvest, procurement and storage of stem cells, whether obtained from peripheral blood, cord blood or bone marrow when reinfusion is not scheduled or anticipated to be scheduled within an appropriate time for the Covered Persons covered stem cell transplant diagnosis; and
9. cornea transplants are not covered under this provision of the Plan. Such transplants are covered under the Plan's Hospital/Outpatient facility benefits and will be paid as any other illness.

N. Charges for dental services performed by a doctor of dental Surgery (DDS), or doctor of medical dentistry (DMD) or any Physician licensed to perform dental related oral Surgery, except as indicated below. Covered Expenses include:

1. dental services and oral surgical care to treat intraoral cancer or to treat Accidental Injury to the jaw, sound natural teeth, mouth or face due to external trauma. The Surgery and services to treat Accidental Injury must be started within three (3) months and completed within twelve (12) months of the accident;
2. dental services not listed above, such as general anesthesia, nursing and related Hospital expenses in connection with an Inpatient or Outpatient dental procedure are covered only when one (1) of the conditions below is met:
    a. complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;
    b. concomitant systemic disease for which the Covered Person is under current medical management and that significantly increases the probability of complications;
    c. mental illness or behavioral condition that precludes dental Surgery in the office;
    d. use of general anesthesia and the Covered Person's medical condition requires that such procedure cannot be provided safely in a dental office setting; and
3. oral appliances to treat obstructive sleep apnea, if Medically Necessary.

Inpatient confinements and Outpatient Surgery procedures are subject to the pre-certification requirements described in Article VI.

The following services are not covered under the Plan:

1. routine dental care and related services including, but not limited to:
    a. crowns;
    b. caps;

c. plates;
d. bridges;
e. dental x-rays;
f. fillings;
g. tooth extractions, except as listed above;
h. periodontal Surgery;
i. root canals;
j. preventive care (cleanings, x-rays);
k. replacement of teeth (including implants, false teeth and bridges);
l. bone grafts (alveolar Surgery);
m. treatment of Injuries caused by biting and chewing;
n. treatment of teeth roots; or
o. treatment of gums surrounding the teeth;

2. treatment for correction of underbite, overbite and misalignment of the teeth including braces for dental indications, orthognathic Surgery and occlusal splints and appliances to treat malocclusion/misalignment of teeth; or
3. extraction of impacted teeth, including wisdom teeth.

O. Charges for the following services and supplies for temporomandibular joint syndrome or dysfunction (TMJ or TMD):
1. diagnosis and treatment of TMJ/TMD;
2. surgical treatment of TMJ/TMD if performed by a qualified oral surgeon or maxillofacial surgeon; and
3. non-surgical TMJ services, including:
a. history exam;
b. office visit;
c. x-rays;
d. diagnostic study casts;
e. medications; and
f. appliances to stabilize jaw joint.

The following are not covered:
1. routine dental care and related services including, but not limited to:
a. crowns;
b. caps;
c. plates;
d. bridges;
e. dental x-rays;
f. fillings;
g. tooth extractions, except as listed above;
h. periodontal Surgery;
i. root canals;
j. preventive care (cleanings, x-rays);
k. replacement of teeth (including implants, false teeth and bridges);

l. bone grafts (alveolar Surgery);
m. treatment of Injuries caused by biting and chewing;
n. treatment of teeth roots; or
o. treatment of gums surrounding the teeth; or

2. treatment for correction of underbite, overbite and misalignment of the teeth including braces for dental indications.

P. Charges for diagnostic radiology services and laboratory tests including:
1. imaging services ordered by a Physician, including x-ray, ultrasound, bone density test and Advanced Radiological Imaging services;
2. Proton Beam Therapy, brachytherapy and radiology, subject to the pre-certification requirements listed in Article VI;
3. sleep studies; and
4. other diagnostic services ordered by a Physician.

Q. Charges for medical equipment or items that in the absence of illness or injury are of no medical or other value to the Covered Person, that can withstand repeated use in an ambulatory or home setting, that require the prescription of a Physician for rental or purchase, that are approved by the FDA for the illness or injury in which prescribed and that are not solely for the convenience of the Covered Person. Covered Expenses include:
1. rental of durable medical equipment (DME) not to exceed the Reasonable and Customary amount for purchase of the item. If the Covered Person rents the same type of equipment from multiple DME Providers and the total rental charges from the multiple Providers exceeds the purchase price of a single piece of equipment, the Covered Person will be responsible for the amounts in excess of the Reasonable and Customary charge for that item. This provision does not apply to any Durable Medical Equipment if the Plan Administrator determines that standard industry practice is to make the equipment available only for rent (such as oxygen concentrators) or only purchase (such as bone growth stimulators). In either of these situations, Covered Expenses will be based on the Reasonable and Customary charge for the standard method of delivery of these items;
2. the repair, adjustment or replacement of components and accessories necessary for the effective functioning of covered DME;
3. supplies and accessories necessary for the effective functioning of covered DME; and
4. the replacement of items needed as the result of normal wear and tear, defects, obsolescence or aging. Insulin pump replacements are covered only for pumps older than forty-eight (48) months and only if the pump cannot be repaired.

The following are not covered:
1. charges exceeding the Reasonable and Customary charge to purchase the DME;
2. unnecessary repair, adjustment or replacement or duplicates of any such DME;
3. supplies and accessories that are not necessary for the effective functioning of the equipment;
4. items to replace those that were lost, damaged, stolen or prescribed as a result of new technology, except when the new technology is replacing items as a result of normal wear and tear, defects or obsolescence and aging;
5. items that require or are dependent on alteration of home, workplace or transportation vehicles;
6. motorized scooters, exercise equipment, hot tubs, pools or saunas;

7. "deluxe" or "enhanced" equipment. The most basic equipment that will provide the needed Medical Care will determine the benefit;
8. computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs and seat lifts of any kind;
9. patient lifts, auto tilt chairs, air fluidized beds or air flotation beds; or
10. portable ramp for a wheelchair.

R. Charges for prosthetic and orthotic devices used to correct or replace all or part of a body organ or limb that may be malfunctioning or missing due to a birth defect, accident, illness or Surgery. Covered Expenses include:

1. the initial purchase of surgically implanted prosthetic or orthotic devices;
2. the repair, adjustment or replacement of components and accessories necessary for the effective functioning of equipment;
3. splints and braces that are custom made or molded, and are incident to a Physician's services or order;
4. the replacement of items required as a result of growth, normal wear and tear, defects or aging;
5. the initial purchase of artificial limbs or eyes;
6. prosthetic bras following a mastectomy, subject to the limitations listed in Section 2.8;
7. wigs following chemotherapy or radiation therapy, subject to the limitations listed in Section 2.8;
8. hearing aids, subject to the limitations listed in Section 2.8; and
9. custom foot orthotics for the treatment of diabetes or if part of a leg brace. Diabetic shoes and inserts are subject to the limitations listed in Section 2.8.

The following are not covered under this provision:

1. prosthetics primarily for Cosmetic purposes, including but not limited to wigs, for reasons other than those stated above, or other hair prosthesis or transplants;
2. items to replace those that were lost, damaged, stolen or prescribed as a result of new technology;
3. the replacement of contacts after the initial pair has been provided following cataract Surgery;
4. foot orthotics, unless listed above as covered; or
5. hearing aid batteries, cords and other assistive listening devices such as FM systems.

S. Charges for services and supplies for the diagnosis and treatment of diabetes, such services must be prescribed and certified by a Physician as Medically Necessary. The treatment of diabetes consists of medical equipment, supplies and Outpatient self-management training and education, including nutritional counseling. Covered Expenses include:

1. insulin pumps, infusion devices and appurtenances, not subject to the DME limitations. Insulin pump replacement is only covered for pumps older than forty-eight (48) months and if the pump cannot be repaired; and
2. podiatric appliances and foot orthotics for prevention of complications associated with diabetes are subject to the limitations in 2.8.

Treatments or supplies that not prescribed and certified by a Physician as being Medically Necessary are not covered under this Plan.

T. Charges for expendable and disposable medical supplies for the treatment of illness or injury, including:

1. supplies for the treatment of illness or injury used in a Physician's office, Outpatient facility or Inpatient facility; and
2. supplies for the treatment of illness of injury that are prescribed by a Physician and cannot be obtained without a Physician's prescription.

Supplies that can be obtained without a prescription, except for diabetic supplies, are not covered under this Plan, including, but not limited to:

1. adhesive bandages;
2. dressing material for home use;
3. antiseptics;
4. medicated creams and ointments;
5. cotton swabs; and
6. eyewash.

U. Charges for home health care services and supplies provided in the Covered Person's home, subject to the pre-certification requirements described in Article VI. Covered Expenses include:

1. part-time, intermittent health services, supplies and medications, by or under the supervision of a registered nurse;
2. home infusion therapy;
3. rehabilitative therapies such as physical therapy, occupational therapy, etc. are subject to the therapy limitations listed in Section 2.8;
4. medical social services; and
5. dietary guidance.

The following items are not covered:

1. routine transportation;
2. homemaker or housekeeping services;
3. behavioral counseling;
4. supportive environmental equipment;
5. Maintenance or Custodial Care;
6. social casework;
7. meal delivery;
8. personal hygiene;
9. other convenience items; and
10. private duty nursing.

V. Charges for hospice care services and supplies when the Covered Person has a life expectancy of six (6) months or less. Inpatient confinements are subject to the pre-certification requirements described in Article VI. Covered Expenses include:

1. part-time intermittent nursing care;
2. medical social services;
3. bereavement counseling;
4. medications for the control or palliation of the illness;
5. home health aide services; and
6. physical or respiratory therapy for symptom control.

The following services are not covered:

1. homemaker or housekeeping services;
2. meals;
3. convenience or comfort items not related to the illness;
4. supportive environmental equipment;
5. private duty nursing;
6. routine transportation; and
7. funeral or financial counseling.

W. Charges for the treatment of Mental/Nervous Disorders, Alcoholism and Substance Abuse disorders (behavioral health conditions). Covered Expenses include:

1. Inpatient services for care and treatment, subject to the pre-certification requirements described in Article VI;
2. Outpatient facility services including, partial hospitalization and intensive Outpatient treatment programs;
3. *effective October 2, 2019*, behavioral therapy, play therapy, communication therapy and therapy for self-correcting language dysfunctions as part speech, physical and occupational therapy programs; and
4. other Outpatient services, including Physician office visits for care and treatment.

X. Charges for the diagnosis and treatment of diseases and injuries that impair vision. Covered Expenses include:

1. services and supplies for the diagnosis and treatment of diseases and injuries to the eye;
2. the first set of eyeglasses or contact lenses required to adjust for vision changes due to cataract Surgery and obtained within six (6) months following the Surgery; and
3. one (1) retinopathy screening for diabetics, subject to the limitations listed in Section 2.8.

Y. Charges for genetic or genomic testing when determined to be Medically Necessary, with prior authorization recommended. BRCA testing is covered under the Recommended Wellness Services and is not subject to any prior authorization recommendations.

Z. Charges for tobacco cessation counseling, subject to the limitations listed in Section 2.8.

AA. Charges for Never Events.

AB. Charges for compression stockings.

AC. Charges for enteral feedings when a Covered Person has a covered diagnosis and is dependent on enteral/parenteral feedings for their sole source of nutrition or if the Covered Person has a disease of the small bowel that necessitates such feedings to maintain weight and strength.

AD. Charges for pharmaceuticals for the treatment of disease or Injury, including:

1. treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a Physician; and
2. pharmaceuticals that are dispensed or intended for use while the Covered Person is confined in a hospital, skilled nursing facility or other similar facility.

Pharmaceuticals that may be purchased without a Prescription are not covered. Pharmacy based prescription drugs are covered under the separate prescription drug programs, as described in Article X.

AE. Charges for Specialty Drugs for the treatment of disease, administered by a Physician or Home Health Care Agency. The following are not covered:

1. self-administered Specialty Drugs, unless covered under the Plan's prescription drug programs; and
2. FDA approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one (1) of the standard reference compendia are not covered under this provision of the Plan.

AF. Charges for dialysis services, subject to the provisions set forth in Section 2.6 and 2.7 of the Plan. Coverage includes the daily cost of dialysis services, diagnostic testing, laboratory tests, equipment and supplies under the Plan to the extent they are Medically Necessary.

Dialysis services, diagnostic testing, lab expenses, equipment and supplies are those services and items used in the treatment of acute renal failure and/or chronic renal insufficiency (treatment of anemia and other diagnoses related to renal failure). This also includes injectable and intravenous medications including but not limited to Heparin, Epogen, Procrit and other medications administered directly before, during or after a dialysis procedure. Dialysis procedures are for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis regardless of whether they are provided on an Inpatient or Outpatient basis.

As outlined within the Schedule of Benefits in Section 2.6 and 2.7, the Plan provides an alternative basis for payment of claims associated with Outpatient dialysis-related services and products. This alternative basis may be applied to claims by any healthcare provider, regardless of the healthcare provider's participation in the Preferred Provider organization (PPO). Effective October 1, 2019, this provision shall only apply to Covered Persons who are either full-time students or Dependent children that are under the custody of an individual not enrolled in the Plan who resides outside of the service area of the Preferred Provider network, as determined by the Plan Administrator, as described in Section 2.2A.

All eligible Participants and their Dependents requiring dialysis are subject to cost containment review, claim audit and/or review, negotiation and/or other related administrative services which the Plan Administrator may elect to apply in the exercise of the Plan Administrator's discretion.

Covered Persons that are diagnosed with a condition requiring dialysis may be able to enroll in Medicare. The Plan will not enroll any Covered Person in Medicare; it is the Covered Person's decision and responsibility to enroll in Medicare, if applicable.

AG. Charges for bariatric Surgery, including related services for weight loss or to treat obesity. *Effective October 1, 2019,* gastric bypass surgeries are subject to the pre-certification requirements listed in Article VI.

AH. *Effective October 2, 2019,* charges for services or supplies for Medically Necessary orthognathic Surgery, a discipline to specifically treat malocclusion.

AI. *Effective October 2, 2019,* charges for Medically Necessary routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches and weak feet or chronic foot strain.

ARTICLE X
OTHER BENEFITS

10.1 PRESCRIPTION DRUG CARD PROGRAM

The Plan has a prescription drug card program that covers prescriptions dispensed through a participating pharmacy. There is a Copayment for most prescriptions that applies only after the prescription Deductible has been met, if applicable, as described in Section 2.9. Such Copayment must be paid for each such prescription obtained until the Out-of-Pocket limit is satisfied. Any Copayment paid under the prescription drug card program shall not be a Covered Expense under any other provision of this Plan.

10.2 MAIL ORDER PRESCRIPTION PROGRAM

The Plan provides a mail order prescription drug program for maintenance drugs only. The Plan covers both brand name and generic equivalents in accordance with the Copayment amounts shown in Section 2.9 of the Plan. The Plan covers up to a ninety (90) day supply of the maintenance medication with a single Copayment. Any Copayment paid under the mail order prescription program shall not be a Covered Expense under any other provision of this Plan.

10.3 COVERED EXPENSES UNDER THE PRESCRIPTION DRUG CARD AND MAIL ORDER PRESCRIPTION PROGRAMS

Prescriptions covered under the prescription drug card and the mail order prescription programs include the following:

A. federal legend drugs not specifically excluded below. A prescription legend drug is any medicinal substance that is required to bear the label, "Caution: Federal law prohibits dispensing without a prescription" or "Rx only";

B. drugs that are part of the Recommended Wellness Services, including:
   1. low dose aspirin products (up to 325 mg);
   2. bowel preparatory kits;
   3. certain breast cancer risk reduction products for females, such as Tamoxifen and Evista;
   4. sodium fluoride products, not including combinations;
   5. folic acid products, not including combinations;
   6. flu shots and shingles and pneumonia vaccines;
   7. iron suspension, ferrous sulfate;
   8. Vitamin D3 (1,000 unit and 400 unit) supplements; and
   9. statins.

C. FDA approved tobacco cessation products for ages eighteen (18) and older, including over-the-counter with a Physician's prescription, limited to ninety (90) days per attempt and up to two (2) attempts per year;

D. FDA approved contraceptive products, including over-the-counter with a Physician's prescription, for females, including female condoms, diaphragms and cervical caps, sponge VCF, patches, NuvaRing, norethindrone, oral (including Seasonale and Seasonique), transdermal, intravaginal, injectable, including Depo Provera, IUDs and emergency (including Plan B/Next Choice);

E. insulin and syringes with or without needles for use with insulin;

F. certain other diabetic supplies, including alcohol swabs, blood/urine test strips, acetone test strips, lancets, control solutions, Glucagon emergency kits, continuous glucose monitor/transmitters/sensors and blood glucose testing monitors;

G. drugs for the treatment of attention deficit disorder (ADD/ADHD). Prior authorization is required over the age of twenty-one (21);
H. oral drugs, limited to six (6) tablets per month, and certain injectable medications for the treatment of erectile dysfunction or impotency, including testosterone;
I. androgens and anabolic steroids, including testosterone;
J. drugs for the treatment of decreased libido in females, such as Addyi;
K. topical vitamin A derivatives and other acne treatments, such as Retin-A, Altinac and Avita. Prior authorization is required if age twenty-one (21) or older on topical derivatives;
L. legend prenatal vitamins, hematinics, folic acid and vitamin D;
M. vitamin B12 (iron) injections;
N. infant formulas, not including nutritional supplements, with prior authorization required;
O. allergy serums;
P. emergency allergic kits;
Q. hemophilia factors, with prior authorization required;
R. injectable migraine medications. Dispensing limitations may apply;
S. non-specialty implantable medications;
T. standard self-injectable medications, with prior authorization required;
U. standard Specialty Drugs, unless specifically listed as excluded, with prior authorization required;
V. influenza treatments, limited to one (1) box per prescription and two (2) boxes per Calendar Year;
W. inhaler assisting devices such as Inspirease and Aerochamber, including over-the-counter products;
X. pre-packaged products greater than a thirty (30) day supply;
Y. substance abuse treatment products such as Antabuse, Methadone and Campral;
Z. compound medications, with prior authorization required;
AA. dental topical fluoride products;
AB. growth hormones, with prior authorization required;
AC. Praluent and Repatha, with prior authorization required;
AD. Accutane (Isotretinoin). Prior authorization is required if age twenty-one (21) or older;
AE. shampoos and soaps, with prior authorization required;
AF. oral Progesterone;
AG. chemotherapy products such as Xeloda, Iressa and Tarceva, with prior authorization required;
AH. oral immunosuppressants (prior authorization is required for injectables); and
AI. other injectable medications not previously listed, with prior authorization required.

10.4 LIMITATIONS UNDER THE PRESCRIPTION DRUG CARD AND MAIL ORDER PRESCRIPTION PROGRAMS

The following items are excluded from the prescription drug card and mail order prescription programs:

A. drugs dispensed in excess of any age or other limitation listed above;
B. drugs listed above as requiring prior authorization if such authorization is not obtained;
C. diabetic supplies other than those specifically listed as covered above, such as insulin pumps and supplies and over-the-counter hypoglycemic products;

D. contraceptives not specifically listed above as covered, including male contraceptives, contraceptives not approved by the FDA, other implantable contraceptives and contraceptive devices;
E. over-the-counter products not specifically listed as covered above;
F. fertility medications;
G. anorexiants, anti-obesity drugs and appetite suppressants;
H. hair growth stimulants and other products indicated only for cosmetic use;
I. nutritional supplements not specifically listed above as covered;
J. Auvi-Q;
K. blood, blood plasma and biological sera;
L. ostomy supplies;
M. repackaged medications;
N. combination drugs;
O. prescriptions filled through Walgreens Pharmacy; and
P. other drugs and products not specifically listed as covered.

ARTICLE XI
EXCLUSIONS AND LIMITATIONS

11.1 GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses Incurred by all Covered Persons and to all benefits provided by this Plan. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided for under this Plan, or that the exclusion is prohibited under any applicable law. The exclusions listed below will not apply to the extent that they relate to an injury the source of which is directly caused by an act of domestic violence committed on a Covered Person. In addition, such exclusions will not apply to an underlying medical condition (including both physical and mental health conditions) triggered by an act of domestic violence. Additional exclusions that apply to the prescription programs are listed in Article X.

A. Charges for services or supplies that are determined to be not Medically Necessary and Medically Appropriate.

B. Charges for services or supplies that are Investigational in nature including, but not limited to, drugs/medications, biologicals, devices and treatments.

C. Charges for illness or injury resulting from war or an act of war that occurred before the Covered Person's coverage began under this Plan and that is covered by veteran's benefits or other coverage for which the Covered Person is legally entitled.

D. Charges for self-treatments or training.

E. Charges for staff consultations required by a Hospital or other facility rules.

F. Charges for services that are free.

G. Charges for services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage.

H. Charges for office visits, physical exams and related immunizations and tests when required solely for sports, camp, employment, travel, insurance, marriage or legal proceedings, unless covered under the Recommended Wellness Services.

I. Charges for dental services, unless specifically listed as covered.

J. Charges for the following reproductive services:
    1. services or supplies that are designated to create a pregnancy, enhance fertility or improve conception quality, and complications that arise from such services, including but not limited to:
        a. artificial insemination;
        b. invitro fertilization;
        c. fallopian tube reconstruction;
        d. uterine reconstruction;
        e. assisted reproductive technology (ART), including but not limited to GIFT and ZIFT;
        f. fertility injections and/or drugs; or
        g. services for follow-up care related to infertility treatments;
    2. services or supplies for the reversals of sterilizations; or
    3. induced abortions, unless specifically listed as a Covered Expense.

K. Charges for services, supplies or prosthetics primarily to improve appearance. This exclusion includes surgeries to correct or repair the results of a prior Surgical Procedure,

the primary purpose of which was to improve appearance, and surgeries to improve appearance following a prior Surgical Procedure, even if that prior procedure was a Covered Expense.

L. Charges for voice modification Surgery or voice therapy.

M. Charges for transportation, meals, lodging or similar expenses, unless specifically listed as covered.

N. Charges for pastoral counseling.

O. Charges for marriage and family counseling without a Behavioral Health Condition diagnosis.

P. Charges for vocational and educational training and/or services.

Q. Charges for conditions without recognizable ICD codes, such as adult child of alcoholics, co-dependency and self-help programs.

R. Charges for sleep disorders, unless specifically mentioned as covered.

S. Charges for court ordered examinations and treatment, unless Medically Necessary.

T. Charges for hypnosis or regressive hypnotic techniques.

U. Charges for services, Surgeries and supplies to detect or correct refractive errors of the eyes, eyeglasses, contact lenses and examinations for the fitting of eyeglasses and contact lenses, eye exercises and/or therapy, or visual training, unless specifically listed as covered.

V. Charges for personal, physical fitness, recreational and convenience items and services such as:

1. barber and other beauty services;
2. television;
3. air conditioners/heaters;
4. humidifiers;
5. air filters;
6. physical fitness equipment;
7. saunas;
8. whirlpools;
9. water purifiers;
10. swimming pools;
11. tanning beds;
12. weight loss/physical fitness programs;
13. devices and computers to assist in communication or speech; or
14. self-help devices that are not primarily medical in nature, even if ordered by a Physician.

W. Charges for services or supplies received before the Covered Person's effective date for coverage under this Plan.

X. Charges for services or supplies related to a Hospital Confinement received before the Covered Person's effective date for coverage under this Plan.

Y. Charges for services or supplies received after the Covered Person's coverage under this Plan ceases for any reason, unless specifically listed as covered. This is true even though the expenses relate to a condition that began while the Covered Person was covered.

Z. Charges for services or supplies received in a dental or medical department maintained by or on behalf of the Employer, mutual benefit association, labor union or similar group.

AA. Charges for services to complete a claim form or to provide medical records or other administrative functions.

AB. Charges for failure to keep a scheduled appointment.

AC. Charges for telephone consultations, e-mail or web-based consultations, except as may be provided for by specially arranged Care Management programs or emerging health care programs and Telehealth visits.

AD. Charges for court ordered examinations and treatment, unless determined to be Medically Necessary.

AE. Charges for Room and Board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.

AF. Charges in excess of the Reasonable and Customary amounts for Covered Expenses.

AG. Charges for services performed by a Close Relative of the Covered Person or by the Covered Person him or herself.

AH. Charges for handling fees.

AI. Charges for nicotine replacement therapy and aids to tobacco cessation, including, but not limited to, patches. Tobacco cessation products may be obtained through the prescription drug card and mail order prescription programs.

AJ. Charges for human growth hormones.

AK. Charges for safety items, or items to affect performance primarily in sports-related activities.

AL. Charges for services or supplies, excluding bariatric Surgery and related services, for weight loss or to treat obesity, even if the Covered Person has other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether the Covered Person is of normal weight, overweight, obese or morbidly obese.

AM. Charges for services or supplies related to treatment of complications, except Complication of Pregnancy, that are a direct or closely related result of a Covered Person's refusal to accept treatment, medicines or a course of treatment that a Physician has recommended or has been determined to be Medically Necessary, including leaving an Inpatient medical facility against the advice of the treating Physician.

AN. Charges for services that are considered to be Cosmetic, except when Medically Necessary or Medically Appropriate or if specifically listed as covered. This exclusion also applies to Surgeries to improve appearance following a prior Surgical Procedure, including weight loss Surgery, even if that prior procedure was a Covered Expense. Services that would be considered Cosmetic include, but are not limited to:

1. breast augmentation, unless following a mastectomy;
2. sclerotherapy injections, laser or other treatment of spider veins and varicose veins;
3. rhinoplasty;
4. panniculectomy/abdominoplasty; or
5. botulinum toxin.

Services that are always considered to be Cosmetic include, but are not limited to:

1. removal of tattoos;
2. facelifts;

3. body contouring or body modeling;
4. injections to smooth wrinkles;
5. piercing ears or other body parts;
6. rhytidectomy or rhytidoplasty;
7. thighplasty;
8. brachioplasty;
9. keloid removal;
10. dermabrasion;
11. chemical peels;
12. lipectomy; or
13. laser resurfacing.

AO. Charges for blepharoplasty or browplasty.

AP. Charges relating to surrogate pregnancy when the surrogate mother is not a Covered Person under this Plan.

AQ. Charges for sperm preservation.

AR. Charges for services or supplies for Maintenance Care.

AS. Charges for private duty nursing.

AT. Charges for services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia or decreased libido.

AU. Charges for cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.

AV. Charges for chelation therapy, except for the following conditions:

1. for control of ventricular arrhythmias or heart block associated with digitalis toxicity;
2. Emergency treatment of hypercalcemia;
3. extreme conditions of metal toxicity, including thalassemia with hemosiderosis;
4. Wilson's disease (hepatolenticular degeneration); or
5. lead poisoning.

AW. Charges for vagus nerve stimulation for the treatment of depression.

AX. Charges for balloon sinuplasty for treatment of chronic sinusitis.

AY. Charges for the treatment of benign gynecomastia.

AZ. Charges for hyperhidrosis.

BA. Charges for biofeedback therapy.

BB. Charges for intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.

BC. Charges for methadone and methadone maintenance therapy.

BD. Charges submitted by a Provider for services which have been unbundled contrary to the Centers for Medicare and Medicaid Services (CMS) guidelines under the Medicare program.

BE. Charges for implants and devices, such as cochlear implants and bone anchored hearing aids. This exclusion does not apply to standard hearing aids.

BF. Charges related to the Covered Person's commission of a felony, criminal acts other than a felony or participation in a riot or other forms of civil disobedience.

BG. Charges for Custodial Care.

BH. Charges for acupuncture.

BI. *Through October 1, 2019,* charges for services or supplies for orthognathic Surgery, a discipline to specifically treat malocclusion. Orthognathic Surgery is not a Surgery to treat cleft palate or TMJ/TMD.

BJ. *Through October 1, 2019,* charges for routine foot care for the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches and weak feet or chronic foot strain.

BK. Charges for any treatment, services or supplies that are not specifically set forth as covered under this Plan.

ARTICLE XII
GENERAL INFORMATION

12.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare or other types of insurance. A Covered Person may have coverage under this Plan, another health plan of coverage or another kind of insurance policy at the same time. Other health plans of coverage include a group sickness and accident insurance policy or program, a group contract of a health maintenance organization, an individual sickness and accident insurance policy or an individual contract of a health maintenance organization. Other kinds of insurance policies include your automobile insurance policy's medical payments and uninsured motorist's coverage. For example, a person may be covered by an employer's group insurance program and also by the group program provided by a spouse's employer. Or a person may be covered by an employer's group insurance and also have coverage under a parent's group plan.

If a Covered Person files a claim under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan or insurance policy will be no more than the usual, Customary, and Reasonable fee payments.

Once a Covered Person has provided this Plan with information about other health benefit plans and/or health benefits through other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination will be determined, as described below.

The plan that pays first is called the primary plan. Any other plan that covers the Covered Person is called the secondary plan.

A. A group or individual plan or policy that does not contain a COB feature is always primary.

B. A plan that covers a person as the certificate holder or the contract holder is primary. In the two examples given, the coverage the person has through his or her employer would be primary. The coverage through a spouse's or parent's employer would be secondary. The exception to this would be when the laws and regulations governing Medicare require that the plan covering the person as a Dependent pay its benefits as primary to Medicare, but such laws and regulations also provide that the plan covering them as the certificate holder/contract holder should pay its benefits as secondary to Medicare. In such a case, the plan that is required to pay as primary to Medicare shall also pay as primary to the other coverage.

C. If a person is covered as a Dependent child under more than one (1) plan:

   1. For a Dependent child whose parents are married or are living together, even if they have never been married, the plan of the parent whose birthday falls earlier in the Calendar Year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose coverage has been in effect the longest is primary (such determination is described in Subsection F below). The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule."

   2. For a Dependent child whose parents are divorced, separated or are not living together (whether or not they have ever been married):

      a. If a court decree states that one (1) of the parents is responsible for the Dependent child's healthcare coverage, and the plan of that parent has actual knowledge of

those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, such spouse's plan is the primary plan. This item shall not apply with respect to any Plan Year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

b. If a court decree states that both parents are responsible for the Dependent child's health care coverage, the birthday rule, as described in C1 above, shall apply.

c. If a court decree states that the parents have joint custody without specifying that one (1) parent has responsibility for the health care coverage of the Dependent child, the birthday rule, as described in C1 above, shall apply.

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

i) the plan of the custodial parent, if any, shall pay its benefits first;

ii) the plan of the spouse of the custodial parent, if any, will pay next;

iii) the plan of the non-custodial parent, if any, will pay after the prior listed plans; and

iv) the plan of the spouse of the non-custodial parent, if any, shall pay it benefits last.

D. A plan that covers a person as an active employee or as a Dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a Dependent of a laid-off or retired employee. The exception to this rule is when the laws and regulations governing Medicare require that this Plan pay its benefits as primary to the plan covering the inactive employee.

E. If a person is covered pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is primary to the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law. The exception to this rule is when the laws and regulations governing Medicare require that the plan covering the person pursuant to COBRA, or under a right of continuation pursuant to state or other federal law, pay its benefits as primary to the other plan.

F. There are some situations in which the above rules do not apply. Here the program that has been in effect longer is primary. To determine the length of time a person has been covered under a plan, two (2) successive plans through the same employer shall be treated as one (1) if the person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended. The person's length of time covered under a plan is measured from his or her first date of coverage under that plan. If that date is not readily available, the date the person first became a member of that group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force. Some examples of when coordination of benefits is based on coverage in effect longer are:

1. when a person who works two (2) jobs has health coverage through both employers; or

2. when a person is covered as the dependent of his or her spouse and a parent. If both coverages become effective on the same date, the birthday rule, as described in C1 above, will apply to this situation.

G. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile accident with an uninsured

motorist, his or her automobile policy's uninsured motorist's coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

If coverage under this Plan is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, this Plan's payments will be calculated by subtracting the primary plan's benefits for the services and supplies covered under this Plan from the Reasonable and Customary allowance for the services and supplies. Of course, the Plan will not pay more when secondary than it would if primary. By accepting coverage under this Plan, a Covered Person agrees to do two (2) things to enable the Plan to coordinate benefits. First, the Covered Person will supply the Plan with information about other coverage he or she has when asked. Second, if the Plan makes a payment and later finds out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e., insurance companies and other persons.

In the case of Medicare services that are furnished to End Stage Renal Disease ("ESRD") Participants who are covered under this Plan:

If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first thirty (30) months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

In order to coordinate Covered Expenses under this Plan with Medicare coverage, the Covered Person is required to:

A. notify the Plan Administrator and send a copy of his or her Medicare card when enrolled in Medicare; and
B. notify the Plan Administrator if or when he or she begins to receive dialysis treatments.

If Medicare reimbursement rates are neither available nor applicable, rates will be set in accordance with this Plan's Customary and Reasonable provision and other provisions.

12.2 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

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

A Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf

of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one (1) party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one (1) or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

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

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

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

If the Covered Person(s) fails to file a claim or pursue damages against:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and without regard to

whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

Covered Person is a Trustee Over Plan Assets

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

A. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
B. instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
C. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
D. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) Incurred prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Excess Insurance

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

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

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

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

A. cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
B. provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
C. take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
D. do nothing to prejudice the Plan's rights of subrogation and reimbursement;

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

F. notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;

G. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

H. not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

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

J. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

K. to make good faith efforts to prevent disbursement of settlement funds until such time as any Dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

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

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section

shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

12.3 MEDICARE BENEFITS

This provision prevents duplication of benefits for Covered Expenses when Medical Care benefits are available from Medicare. Benefits under this Plan will be reduced to the extent that the Participant or his or her Dependents are reimbursed or entitled to reimbursement for those expenses by Medicare.

Under the Tax Equity and Fiscal Responsibility Act of 1982, as amended (TEFRA), active employees and/or their spouses who are sixty-five (65) or over may choose to have the County program as primary coverage, in which case Medicare may pay benefits on a secondary basis. Otherwise, an employee may elect to drop out of the company program and choose Medicare as primary coverage. Employees in this category who are enrolled under this Plan will remain so enrolled with this Plan as primary coverage unless an option form is on file indicating otherwise.

The Plan may also pay its benefits as primary to Medicare's in other situations, as prescribed by applicable laws and regulations.

The Plan intends to comply with the federal Social Security Act, as amended, and other applicable laws, as such apply to Medicare benefits.

12.4 ADDITIONAL RIGHTS OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant. Once the Plan Administrator determines that a previous benefit payment should be reimbursed, in whole or in part, either due to the provisions described in Section 12.2 or because such benefit payment should not have been made in accordance with the provisions of this Plan, the Participant and/or the applicable Provider will be notified of such overpayment, and a request will be made for such Participant/Provider to reimburse the Plan. If the reimbursement is not made as requested, such amount will constitute a lien against future claim payments that would otherwise be paid on the Participant or the Covered Person's behalf. The Plan Administrator retains the right to reduce or withhold such future claim payments until the lien is satisfied.

This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

12.5 FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager 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, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

12.6 ADMINISTRATION OF THE PLAN

The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under any applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;

B. to construe and interpret this Plan;

C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;

D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;

E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;

F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;

G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;

H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;

I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of any applicable laws, and all regulations promulgated thereunder; and

J. to retain counsel (who may, but need not, be counsel to the County), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

12.7 NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service Provider; provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service Provider shall be binding on the Plan only if:

A. the Plan Administrator or Benefit Manager is notified of such assignment prior to payment of benefits;
B. the assignment is made on a form provided by, or approved by, the Plan Administrator or the Benefit Manager; and
C. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or Benefit Manager.

12.8 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 another time, nor will such failure affect the right to enforce any other provision.

12.9 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under any applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in any applicable laws.

12.10 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care Provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care Provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any Provider of services or supplies under this Plan. Neither the Plan, nor the Plan Administrator, nor the Benefit Manager have any responsibility for or control over the actions of any Preferred Provider networks offering services and/or supplies under the Plan.

12.11 ADMINISTRATIVE AND CLERICAL ERRORS

The benefits payable to or on behalf of a Participant or Dependent under this Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Benefit Manager. If written application for coverage for an eligible employee or Dependent is submitted by the employee/Participant within the applicable time frame specified in Article V, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Benefit Manager shall not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in

claims processing, utilization review or other administrative functions shall not affect the benefits payable to or on behalf of a Covered Person under this Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator shall have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

12.12 RESCISSION OF COVERAGE

A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide an individual with coverage, just as if he or she never had coverage under the Plan. Such coverage can only be rescinded if the individual (or a person seeking coverage on an individual's behalf) perform an act, practice, or omission that constitutes fraud; or unless the individual (or a person seeking coverage on the individual's behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by an employer.

Such individual will be provided with thirty (30) calendar days' advance notice before coverage is rescinded. Such individual has the right to request an internal appeal of a rescission of his or her coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent external review.

12.13 DISCRIMINATION COMPLAINTS

It is the policy of Anderson County Government not to discriminate on the basis of race, color, national origin, sex, age or disability. The Plan Administrator has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of the Plan's Civil Rights Coordinator, who has been designated by the Plan Administrator to coordinate the efforts of Anderson County Government to comply with Section 1557:

Civil Rights Coordinator
Kim Jeffers-Whitaker
100 N. Main St, Room 102
Clinton, TN 37716
865-264-6300
865-264-6259 (fax)
kwhitaker@andersontn.org

Any person who believes they or someone else has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Anderson County Government to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

The following procedures apply to complaints submitted under these procedures:

A. grievances must be submitted to the Civil Rights Coordinator within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action;
B. a complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought;
C. the Civil Rights Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Civil Rights Coordinator will maintain the files and records of Anderson County Government

Employee Benefit Plan. relating to such grievances. To the extent possible, and in accordance with applicable law, the Civil Rights Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know;

D. the Civil Rights Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than thirty (30) days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies; and

E. the person filing the grievance may appeal the decision of the Civil Rights Coordinator by writing to the Plan Administrator within fifteen (15) days of receiving the Civil Rights Coordinator's decision. The Plan Administrator shall issue a written decision in response to the appeal no later than thirty (30) days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at https://ocrportal.hhs.gov/ocr/portal/lobby.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

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within one hundred eighty (180) days of the date of the alleged discrimination.

The Plan Administrator will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Civil Rights Coordinator will be responsible for such arrangements.

ARTICLE XIII
PRIVACY

13.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

13.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Article VI, including, but not limited to, the review of any grievances or appeals involved in such activities that are generated by the Covered Person or his or her authorized representatives; or

C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:

   1. quality assessment and improvement activities;
   2. evaluation of Plan performance;
   3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
   4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
   5. business planning and development of the Plan;
   6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
   7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

13.3 DISCLOSURES OF HEALTH INFORMATION TO THE COUNTY

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the County only as described below:

A. for any of the purposes and under the conditions described in Section 13.2;

B. as Summary Health Information, if requested by the County for the following purposes:

   1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
   2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the County for the purpose of performing Plan administrative functions.

Prior to any disclosure of Health Information to the County, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the County or Plan Administrator for Plan administration or other Plan purposes to whom it provides

Protected Health Information, including, but not limited to, the Benefit Manager, any Utilization Review Service or pharmacy benefit manager, agree to the same restrictions and conditions that apply to the County with respect to such information;

C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the County;

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;

E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 13.4 and Section 13.5;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

H. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the County still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:

   1. access to Protected Health Information will only be provided to the following categories of County employees:
      a. Director of Human Resources and Risk Management;
      b. Human Resources Benefits Administrator;
      c. Director of Finance;
   2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the County performs for the Plan; and
   3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the County's established employee discipline and termination procedures.

13.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;

B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or

C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will provide access to

the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

13.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the County amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;

B. the information is not currently maintained in any record by the Plan;

C. the information would not be available for inspection under the reasons cited in Section 13.4; or

D. the information in the Plan's records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities that it has knowledge of such entity's receipt of any information that has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial that includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

13.6 SECURITY OF PROTECTED HEALTH INFORMATION

The County will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the County and the Plan to support the requirements of Section 13.3. The County will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.