

**CITY OF CARLSBAD
HEALTH BENEFIT PLAN**

Amendment No. 3

Effective March 20, 2016, the City of Carlsbad Health Benefit Plan (the “Plan”) is hereby amended as follows:

- 1.) The following provision contained in **ARTICLE II, General Plan Information Act** (page 3) is **deleted**:

Patient Protection and Affordable Care Act

This group health plan believes this plan is a “Grandfathered Health Plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

City of Carlsbad
P.O. Box 1569 101 N. Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191

- 2.) The following provision contained in **ARTICLE II, General Plan Information Act** (page 4) is **deleted**:

Plan Status: Grandfathered

It is **replaced** by:

Plan Status: Non-Grandfathered

- 3.) The following provisions contained in **ARTICLE III, Definitions**, (page 10) are **deleted**:

“Dependent”

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

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, “marriage or married” means a legal union between one man and one woman as husband and wife;
2. An Employee’s Child who is less than 26 years of age; or

They are **replaced** by:

“Dependent”

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

1. An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee;
 2. An Employee’s Child until the end of the month in which they attain 26 years of age; or
- 4.) The following provision contained in **ARTICLE III, Definitions**, (page 12) is **deleted**:

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

It is **replaced** by:

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

- 5.) The following provision is added to **ARTICLE III, Definitions**, (page 12):

“Final Internal Adverse Benefit Determination”

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

- 6.) The following specific surgical references as included in the Utilization Management provision as contained in **ARTICLE IV, Summary of Benefits** (pages 23 and 26) are **deleted**. All other provisions remain unchanged:

Outpatient Procedures

- Bariatric (weight loss) Surgery;
- Excess skin removal arms and chest and legs;
- Panniculectomy;

Pre-Surgical Approval

- Abdominoplasty;

- 7.) The following provisions contained in **ARTICLE IV, Summary of Benefits** (pages 29 and 30) are **deleted**:

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Physician Services				
Emergency Room Physician Charges	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Emergency Room Treatment	\$75 Copay, then 0%	10% Coinsurance	30% Coinsurance	10% Coinsurance

They are **replaced** by:

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Physician Services				
Emergency Room Physician Charges	10% Coinsurance	10% Coinsurance	10% Coinsurance	10% Coinsurance
Emergency Room Treatment	\$75 Copay, then 0%	10% Coinsurance	10% Coinsurance	10% Coinsurance

- 8.) The following provisions contained in **ARTICLE IV, Summary of Benefits** (page 31) are **deleted**:

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Other Covered Services				
Morbid Obesity	40% Coinsurance	50% Coinsurance	Not Covered	50% Coinsurance
Physical, Speech and Occupational Therapy – Precertification is required after 12 visits	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance

They are **replaced** by:

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Other Covered Services				
Morbid Obesity <i>(excludes surgical treatment)</i>	40% Coinsurance	50% Coinsurance	Not Covered	50% Coinsurance
Physical, Speech and Occupational Therapy – Precertification is required after 24 visits	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance

9.) The following provision is **deleted from ARTICLE V, Medical Benefits** (page 33),

Approved Cancer Clinical Trials, Patient Care Costs. Payment is limited to in-state or Network cost. Does not cover:

- Cost of an investigational drug, device, or procedure.
- Costs of non-health care services that the patient needs because of clinical trial participation.
- Costs associated with managing the research that is part of the clinical trial.
- Costs that would not be covered by the patient's health plan if standard treatments were provided.
- Costs of extra tests that would not be done except for participation in the clinical trial.
- Cost paid or not charged for by the clinical trial providers.

It is **replaced** by the following:

Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

- a. The clinical trial is approved by:
 - i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
 - ii. The National Institute of Health;
 - iii. The U.S. Food and Drug Administration;
 - iv. The U.S. Department of Defense;
 - v. The U.S. Department of Veterans Affairs; or
 - vi. An Institutional review board of an Institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
- b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

- a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
- b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
- c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
- d. A cost associated with managing an Approved Clinical Trial;
- e. The cost of a health care service that is specifically excluded by the Plan; or
- f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

10.) The following provision is **added** to **ARTICLE V, Medical Benefits** (page 38), and the subsequent provisions are considered to be renumbered accordingly:

27. **Morbid Obesity.** Treatment of Morbid Obesity, which is defined as a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the individual. However, benefits under this Plan will be limited to expenses incurred for non-surgical treatment by a covered provider, and include the following:

- office visits,
- behavior modification and
- required x-ray and laboratory examinations.

11.) The following provision is **added** to **ARTICLE VI, Medical Exclusions and Limitations** (page 43), and the subsequent provisions are considered to be renumbered accordingly:

16. **Obesity.** Care and treatment related to surgical interventions (including complications) which are performed for the purpose of weight loss or dietary control. However, benefits will be available under the Plan for the Medically Necessary treatment of Morbid Obesity that is non-surgical in nature as specified in the Medical Benefits provisions.

Note: Coverage will be available for follow up care performed in conjunction with the surgical treatment of Morbid Obesity if such procedure was performed prior to March 19, 2016. However, any further surgical treatment or associated follow up care will not be eligible for benefits under the Plan.

12.) The provision entitled **When Claims Must Be Filed** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (page 74) is **deleted** in its entirety and **replaced** by the following:

Post-service health claims must be filed with the Third Party Administrator within 365 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Claims filed later than that date shall be denied.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days from receipt by the Participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

- 13.) The provision entitled **Timing of Claims Decisions** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (pages 75-76) is **deleted** in its entirety and **replaced** by the following:

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

- a. If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
- c. The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
 - i. The Plan's receipt of the specified information; or
 - ii. The end of the period afforded the Participant to provide the information.
- d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

- a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

- a. **Plan Notice of Reduction or Termination.** If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or

number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

- b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
- c. Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
- d. Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
 - e.
 - i. Notification to Participant 30 days
 - ii. Notification of Adverse Benefit Determination on appeal 30 days

4. Post-service Claims:

- a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
 - i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
 - ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 - iii. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both

determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

- 14.) The following provisions contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS, Notification of an Adverse Benefit Determination** (page 76) is **deleted**:

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

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

They are **replaced** by the following and the subsequent provisions are considered to be renumbered accordingly:

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

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- 15.) The provisions entitled **Full and Fair Review of All Claims** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (pages 76-77) are **deleted** in their entirety and **replaced** by the following:

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity

for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
8. That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and
9. That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

- 16.) The provisions entitled **Requirements For Appeal** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (pages 77-78) are **deleted** in their entirety and **replaced** by the following:

The Participant must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

HPHG, LLC dba Caprock HealthPlans
PO Box 54139
Lubbock, TX 79453-4139
E-mail: claims@caprockhp.com
Fax: 806-698-5823
Phone: 800-747-9446

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

HPHG, LLC dba Caprock HealthPlans
PO Box 54139
Lubbock, TX 79453-4139
E-mail: claims@caprockhp.com
Fax: 806-698-5823
Phone: 800-747-9446

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

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

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

- 17.) The following provision is added to **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS, Timing of Notification of Benefit Determination on Review** (page 78), and the subsequent provisions are considered to be renumbered accordingly:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- 18.) The provisions entitled **Manner and Content of Notification of Adverse Benefit Determination on Review** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (pages 78-79) are **deleted** in their entirety and **replaced** by the following:

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures;
7. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

- 19.) The provisions entitled **Decisions on Review to be Final** contained in **ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS** (page 79) are **deleted** in their entirety and **replaced** by the following:

Decision on Review

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

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

- b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
 - d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
- a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.
3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

The Plan Document and Summary Plan Description will be amended to reflect these changes. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Amendment #3, Effective March 20, 2016

Accepted By:

City Of Carlsbad Health Benefit Plan Employee Benefit Plan

By: *Jim Ritchie*

Date: 4-25-16

Title: City Administrator

CITY OF CARLSBAD
HEALTH BENEFIT PLAN

Amendment No. 1
Effective August 1, 2014


The City of Carlsbad Health Benefit Plan (the "Plan") is hereby amended as follows:

1. Under ARTICLE IV SUMMARY OF BENEFITS, Provider Network, item 2. that begins, "If the charge billed by a Non-Network Provider. ..." is *omitted and replaced* with the following:
 2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. Usual and Customary Fees are not applied when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency but will be considered at the Provider's billed charges or negotiated rate. Additionally, Participants receiving care not indicated as Emergency care from Non-Network Providers may appeal to the Plan for review of additional payment if the Participant believes there was no option to seek same or like services from a Network Provider. These charges will be considered at the Provider's billed charges or negotiated rate.
2. Under ARTICLE XIV GENERAL LIMITATIONS AND EXCLUSIONS, the exclusion for Excess. is *omitted and replaced* with the following:

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

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:

By  _____
Title: (.bi q
Date: S-- ;[L -1.,j_

CITY OF CARLSBAD HEALTH BENEFIT PLAN

Plan Document and Summary Plan Description

Effective: August 1, 1996

Restated: August 1, 2014

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ARTICLE I
ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by City of Carlsbad (the "Company" or the "Plan Sponsor") as of August 1, 2014, hereby amends and restates the City of Carlsbad Health Benefit Plan (the "Plan"), which was originally adopted by the Company, effective August 1, 1996. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

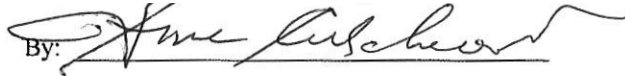
Effective Date

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

Adoption of the Plan Document

The Plan Sponsor, as the settler of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

By: 

Name: Steve McCutcheon

Title: City Administrator

Date: ~~8~~ 8/30/14
/ 1 7

CITY OF CARLSBAD
HEALTH BENEFIT PLAN

Amendment No. 1
Effective August 1, 2014

The City of Carlsbad Health Benefit Plan (the "Plan") is hereby amended as follows:

1. Under ARTICLE IV SUMMARY OF BENEFITS, Provider Network, item 2. that begins, "If the charge billed by a Non-Network Provider..." is *omitted* and *replaced* with the following:
 2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. Usual and Customary Fees are not applied when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency but will be considered at the Provider's billed charges or negotiated rate. Additionally, Participants receiving care not indicated as Emergency care from Non-Network Providers may appeal to the Plan for review of additional payment if the Participant believes there was no option to seek same or like services from a Network Provider. These charges will be considered at the Provider's billed charges or negotiated rate.
2. Under ARTICLE XIV GENERAL LIMITATIONS AND EXCLUSIONS, the exclusion for Excess. is *omitted* and *replaced* with the following:

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

The Plan Document and Summary Plan Description will be amended to reflect this change. All other terms and conditions of the Plan which are not affected by this Amendment are unchanged.

Accepted:





By

Title: (?  _____

Date: S--:/L-1J....._

ARTICLE II INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

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

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **City of Carlsbad** and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Patient Protection and Affordable Care Act

This group health plan believes this plan is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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

**City of Carlsbad
P.O. Box 1569
101 N. Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191**

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

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Name of Plan: City of Carlsbad Health Benefit Plan

Plan Sponsor: City of Carlsbad
P.O. Box 1569
101 N. Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191
Fax: 575-887-5115
Email: hr@cityofcarlsbadnm.com

Plan Administrator: (Named Fiduciary) City of Carlsbad
P.O. Box 1569
101 N. Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191
Fax: 575-887-5115
Email: hr@cityofcarlsbadnm.com

Plan Sponsor ID No. (EIN): 85-6000111

Source of Funding: Self-Funded

Plan Status: Grandfathered

Applicable Law: ERISA

Plan Year: August 1 to July 31

Plan Number: 501

Plan Type: Medical
Dental
Vision
Prescription Drug

Third Party Administrator: HPHG, LLC dba Caprock HealthPlans

Mailing Address: PO Box 54139
Lubbock, TX 79453-4139

Street Address: 4401 82nd Street
Ste 1200
Lubbock, TX 79424
Phone: 800-747-9446
Fax: 806-698-5823

Prescription Drug Plan Administrator: Welldyne
Phone: 888-479-2000
Email/Website: www.welldynernx.com

Participating Employer(s): City of Carlsbad

Agent for Service of Process: City of Carlsbad
P.O. Box 1569
101 N. Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191
Fax: 575-887-5115
Email: hr@cityofcarlsbadnm.com

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

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

Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating Employee welfare and pension plans. Your rights as a Participant in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. Additionally, the Plan will comply with any applicable State PPO prompt pay laws.

Discretionary Authority

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

ARTICLE III DEFINITIONS

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

“Accident”

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

“Accidental Bodily Injury” or “Accidental Injury”

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

“Actively At Work” or “Active Employment”

“Actively At Work” or “Active Employment” shall mean performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

“ADA”

“ADA” shall mean the American Dental Association.

“Adverse Benefit Determination”

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

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

“AHA”

“AHA” shall mean the American Hospital Association.

“Allowable Expenses”

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

“Alternate Recipient”

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

“AMA”

“AMA” shall mean the American Medical Association.

“Ambulatory Surgical Center”

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

“Approved Clinical Trial”

“Approved Clinical Trial” shall mean a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out-of network benefits are otherwise provided under the Plan.

“Assignment of Benefits”

“Assignment of Benefits” shall mean an arrangement whereby the Participant, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” and Deductibles, co-payments and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Participant as the sole beneficiary.

“Cardiac Care Unit”

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

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

“Certificate of Coverage”

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

“Child” and/or “Children”

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

“CHIP”

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

“CHIPRA”

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

“Chiropractic Care”

“Chiropractic Care” shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

“Claim Determination Period”

“Claim Determination Period” shall mean each Plan Year.

“Clean Claim”

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

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

“COBRA”

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

“Copay”

“Copay” means the specified dollar amount that a Participant must pay each time certain covered services are provided, as specified in the Summary of Benefits.

“Cosmetic Surgery”

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

“Covered Expense(s)”

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

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

“Custodial Care”

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

“Deductible”

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

Credit will be given for Deductibles, waiting periods and maximums satisfied, in whole or in part, under the Prior Plan for those Participants receiving coverage under the Prior Plan and considered eligible Participants of this Plan on August 1, 2012.

“Dental Hygienist”

“Dental Hygienist” shall mean a person trained to:

1. Remove calcareous deposits and stains from the surfaces of teeth; and
2. Provide information on the prevention of oral Diseases.

“Dentally Necessary”

“Dentally Necessary” shall mean that a dental service or treatment is performed in accordance with generally accepted dental standards, as determined by the Plan Administrator, and is:

1. Necessary to treat decay, Disease or Injury of the teeth; or
2. Essential for the care of the teeth and supporting tissues of the teeth.

“Dentist”

“Dentist” shall mean:

1. A person licensed to practice dentistry in the jurisdiction where such services are performed; or
2. Any other person whose services, according to applicable law, must be treated as Dentist’s services for purposes of this Plan. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction.

For purposes of dental benefits, the term will include a Physician who performs a covered service.

“Dentures”

“Dentures” shall mean fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

“Dependent”

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

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

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

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

Dependents covered on the previous health plan are exempt from obtaining legal guardianship documents. Newly added dependents beyond August 1, 2012 will be subject to providing legal guardianship documentation.

“Diagnosis”

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

“Diagnostic Service”

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

“Disease”

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

“Doctor of Oriental Medicine”

“Doctor of Oriental Medicine” means a person who is a doctor of oriental medicine (D.O.M.) licensed by the appropriate governmental agency to practice acupuncture and oriental medicine.

“Drug”

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

“Durable Medical Equipment”

“Durable Medical Equipment” shall mean equipment which:

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

“Emergency”

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

“Emergency Medical Condition”

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

“Emergency Services”

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

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

“Emergency Services”

“Emergency Services” shall mean dental services which are required for alleviation of severe pain or for immediate diagnosis and treatment of unforeseen conditions which, if not immediately diagnosed and treated, would lead to serious impairment of the patient’s health.

“Employee”

“Employee” shall mean a person who is a regular full time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an Employer Employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered “full time.”

“Employer”

“Employer” is **City of Carlsbad**.

“ERISA”

“ERISA” shall mean the Employee Retirement Income Security Act of 1974, as amended.

“Essential Health Benefits”

“Essential Health Benefits” shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care ; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

“Experimental” and/or “Investigational”

“Experimental” and/or “Investigational” (“Experimental”) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

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

All phases of clinical trials shall be considered Experimental, except for Phase I through IV Approved Cancer Clinical Trials, as required in New Mexico, in accordance with Senate Bill 42 (“Cancer Clinical Trial Insurance Coverage”) (2009). A drug, device or medical treatment or procedure is Experimental:

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

Reliable evidence shall mean:

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

A transplant procedure will be deemed an “Experimental Treatment” if it is not one of the procedures specified in the Transplant Benefits Section.

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

“Family Unit”

“Family Unit” shall mean the Employee, his or her spouse and Children.

“FMLA”

“FMLA” shall mean the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave”

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

“GINA”

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

“Habilitation/Habilitative Services”

“Habilitation Services” shall mean services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

“HIPAA”

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

“Home Health Care”

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

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

“Home Health Care Agency”

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

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

“Hospital”

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

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

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

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

“Illness”

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

“Impregnation and Infertility Treatment”

“Impregnation and Infertility Treatment” shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

“Incurred”

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

“Injury”

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

“Inpatient”

“Inpatient” shall mean any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

“Institution”

“Institution” shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

“Intensive Care Unit”

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

“Late Enrollee”

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

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

“Leave of Absence”

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

“Legal Separation”

“Legal Separation” shall mean an arrangement to remain married but live apart, following a court order.

“Mastectomy”

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

“Maximum Amount” or “Maximum Allowable Charge”

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

1. The Usual and Customary amount (unless prohibited by the PPO Contract);
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Provider; or
5. The actual billed charges for the covered services.

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

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

“Medical Child Support Order”

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

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

“Medically Necessary”

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

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

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

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

“Medical Record Review”

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

“Medicare”

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

“Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA”

“The Mental Health Parity Provisions” shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

“Mental or Nervous Disorder”

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

“Morbid Obesity”

“Morbid Obesity” is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

“National Medical Support Notice” or “NMSN”

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

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

“Network”

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

“No-Fault Auto Insurance”

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

“Non-Occupational Injury”

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

“Non-Network Fee Schedule (NNFS)”

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

“Nurse”

“Nurse” shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

“Open Enrollment Period”

“Open Enrollment Period” shall mean the month of July in each Plan Year.

“Other Plan”

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

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

“Out of Area”

“Out of Area” shall mean a geographic area, as determined by the Plan Administrator, at the time each Participant becomes eligible for coverage under this Plan.

“Participant”

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

“Physician”

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

“Plan Year”

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

“Pre-admission Tests”

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

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

“Pregnancy”

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

“Preventive Care”

“Preventive Care” shall mean certain Preventive Care services.

This Plan intends to comply with the Patient Protection and Affordable Care Act’s (PPACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> or at <https://www.healthcare.gov/prevention>. For more information, you may contact the Plan Administrator / Employer.

“Primary Care Physician”

A “Primary Care Physician” means a Physician engaged in family practice, general practice, no-specialized internal medicine, (i.e. one who works out of a family practice clinic), pediatrics, obstetrics/gynecology.

“Prior Plan”

“Prior Plan” shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

“Prior to Effective Date” or “After Termination Date”

“Prior to Effective Date” or “After Termination Date” are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

“Privacy Standards”

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

“Provider”

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

“Psychiatric Hospital”

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

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

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

“Qualified Medical Child Support Order” or “QMCSO”

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

“Reasonable”

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

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

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

“Rehabilitation Hospital”

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

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

“Room and Board”

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

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

“Scheduled benefit” or “Scheduled Benefit Amount”

“Scheduled benefit” or “Scheduled benefit amount” shall mean a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled Benefits are based upon Covered Expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of Schedule Benefit Amounts may be found in the section, “Summary of Benefits.” A complete listing of Schedule Benefit Amounts may be obtained on the web site at www.caprockhp.com, or free of charge on request to:

Scot Bendixson
101 N Halagueno
Carlsbad, NM 88220
Phone: 575-887-1191

Scheduled Benefit Amounts are determined taking into consideration (but not restricted to) the lesser of the Usual and Customary fee for services and/or supplies, which are deemed to be both Reasonable and Medically Necessary.

If the Plan Administrator is unable to determine scheduled benefit amounts utilizing the aforementioned process, it shall, at its sole discretion, determine scheduled benefit amounts considering accepted industry-standard documentation uniformly applied without discrimination to any Plan Participant.

“Security Standards”

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

“Service Waiting Period”

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

“Sickness”

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

“Specialist”

A “Specialist” means a Physician, or other provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance abuse providers.

“Substance Abuse”

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

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
 - b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - c. Craving or a strong desire or urge to use a substance; or
 - d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

“Substance Abuse Treatment Center”

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

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

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

“Surgery”

“Surgery” shall mean any of the following:

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

“Surgical Procedure”

“Surgical Procedure” shall have the same meaning set forth in the definition of “Surgery.”

“Third Party Administrator”

“Third Party Administrator” shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

“Total Disability”

“Total Disability” shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

“Totally Disabled”

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

“Uniformed Services”

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

“USERRA”

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

“Usual and Customary”

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

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

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

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

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

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE IV SUMMARY OF BENEFITS

General Limits

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

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

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

All Inpatient admission and/or procedures must be pre-certified

- Dialysis;
- Inpatient Hospitalization;
- Inpatient Mental/Nervous facility based programs;
- Inpatient Substance Abuse facility based programs;
- Skilled Nursing Facility stays;
- Transplant Candidacy Evaluation and Transplant (organ and/or tissue);

Outpatient Procedure

- AICD and Biventricular device insertions;
- AV Fistula or graft access for dialysis;
- Bariatric (weight loss) Surgery;
- Biopsies (while these are for practical purposes always certified we use the information to find cancer cases early);
- Blepharoplasty;
- Breast Reduction;
- Cardiac Catheterization;
- Dialysis;
- Durable Medical Equipment purchase in excess of \$2,000 billed per date of service;
- Excess skin removal arms and chest and legs;
- Following back or neck procedures: IDET (intradiscal Electrothermal Annuloplasty), Percutaneous Radiofrequency Neurotomy, Artificial Intervertebral Disk Implantation, Automated Percutaneous Lumbar Discectomy (APLD);
- Hysterectomies;
- Joint Replacement (Arthrotomy);
- Maxillo-facial surgery- *unless orthognathic surgery is excluded by plan language;
- Nasal surgeries;
- Panniculectomy;
- Rehab program (such as Cardiac, Chemical Dependency, Pain Management, Pulmonary, Physical Therapy, Occupational Therapy, Speech Therapy or Cognitive Therapy);
- Sclerotherapy;
- Shock wave lithotripsy for plantar fasciitis;
- Spinal Surgeries when fusions and implants are used;
- Tonsillectomies/Adenoidectomies in adults;
- UP3/UPPP – uvulopalatopharyngoplasty;
- Varicose vein surgery;
- Ventral hernia repair;

Diagnostic testing

- CT angiogram;
- CT Calcium screening/screening CT of the heart;
- MRI of the heart;
- PET scans; and

Other

- Chemotherapy/radiation oncology.

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

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

Notification is requested for the following services (screen for case management only, not precertification):

- Home Care;
- Hospice services; and
- Infusions/high cost injectables.

Cost Containment

Pre-Certification Procedures

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

Urgent Care or Emergency Admissions:

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

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

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

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

Non-Emergency Admissions:

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

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

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

The pre certification department hours of operations are 8 A.M. to 5 P.M. On weekends and evenings, the Participant can call the phone number located on his/her ID card, and leave a message.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify pre-certification department of any procedure as required in the section entitled "Pre-Certification Procedures", allowed charges will be reduced by a maximum of \$200. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

Alternate Course of Treatment

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

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

Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x ray examinations performed on an outpatient basis within 7 days prior to such Hospital admission will be paid, with no Deductible if at a Network facility, at 100% of the Usual and Customary Fees, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment;
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital;
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary; and
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan **recommends** that a second opinion be obtained **prior to** the following Surgeries:

1. Adenoidectomy;
2. Bunionectomy;
3. Cataract removal;
4. Coronary bypass;
5. Cholecystectomy (removal of gallbladder);
6. Dilation and curettage;
7. Hammer toe repair;
8. Hemorrhoidectomy;
9. Herniography
10. Hysterectomy;
11. Laminectomy (removal of spinal disc);
12. Mastectomy;
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach);
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage);
15. Prostatectomy (removal of all or part of prostate);
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome);
17. Tonsillectomy; and
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay 100% of Usual and Customary Fees incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Pre-Surgical Approval

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

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

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

Provider Networks

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

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
 - a. When a Non-Network radiologist, anesthesiologist, pathologist, or emergency room physician is providing services at a Network facility or a Network Physician's office, the charges Incurred from the services provided by the Non-Network radiologist, anesthesiologist, pathologist, or emergency room physician will be paid at the Network rate. This provision applies only when the Participant has no choice of a Network Provider;
 - b. The Network Provider level of benefits is payable for any Participant who cannot access Network Providers because they reside outside the Network service area. The Network service area is defined as availability of an Network provider within 50 miles of the service location; and
 - c. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.
3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.
4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

Preferred Provider Information

This Plan contains provisions under which a Participant may receive more benefits by using certain Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The Participating Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Participating Provider.

A current list of Participating Providers is available, without charge, through the Third Party Administrator's website (located at www.caprockhp.com). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Relations Department. The Participating Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Participating Provider before receiving services. Please refer to the Participant identification card for the PPO website address.

Claims Audit

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

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

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

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

Plan Year Maximum Benefit

The following calendar year maximums apply to each Participant:

Plan Year Maximum Benefits for:	
All Essential Health Benefits	Unlimited
Acupuncture	\$1,500
Chiropractic Care	\$1,500
Diabetes Education	8 visits
Home Health Care	120 visits
Physical, Speech & Occupational Therapy	60 visits
Skilled Nursing Facility Services	170 days

Summary of Medical Benefits

The following benefits are per Participant per Plan Year:

Note: If a benefit maximum is listed, it is a combined maximum benefit for the services that the Participant receives from all Network and Non-Network providers and facilities.

	Preferred Tier	Network	Non-Network	Out-of-Area
Deductible				
• Individual	\$250	\$500	\$1,000	\$500
• Family Unit	\$750	\$1,000	N/A	\$1,000
The Preferred Tier, Network and Non-Network Deductible accumulate together.				
<i>Combined for Medical and Dental benefits. The Plan Year Deductible must be satisfied before benefit payments are made for services indicated with a "Coinsurance" unless indicated otherwise. The Plan Year Deductible does not apply to services indicated with a "Copay"</i>				
Maximum Out-of-pocket				
• Individual	\$750	\$1,500	\$25,000	\$1,500
• Family Unit	\$2,250	\$3,000	N/A	\$3,000
The Preferred Tier, Network and Non-Network Maximum Out-of-Pocket do NOT accumulate together. The Maximum Out-of-Pocket includes Deductible, Coinsurance and Copays. The Maximum Out-of-Pocket does not include amounts over the Usual and Customary Fees and any penalty amounts for non-compliance with the Plan's precertification provision.				

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Physician Services				
Office Visits				
• Primary Care and Specialists	\$20 Copay, then 0% Coinsurance	\$20 Copay, then 0% Coinsurance	30% Coinsurance	\$20 Copay, then 0% Coinsurance
• Urgent Care	\$30 Copay, then 0% Coinsurance	\$30 Copay, then 0% Coinsurance	30% Coinsurance	\$30 Copay, then 0% Coinsurance
Office Surgery	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Emergency Room Physician Charges	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Hospital, Extended Care and Nursing Home visits	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Outpatient Surgery	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Inpatient Surgery	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Assistant Surgeon or Anesthesiologist	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Professional Opinion when requested by Utilization Review	10% Coinsurance, Deductible waived	10% Coinsurance, Deductible waived	30% Coinsurance, Deductible waived	10% Coinsurance, Deductible waived
Preventive Care				
<ul style="list-style-type: none"> Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations; Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention; Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA). 	\$0 Copay, then 0% Coinsurance	\$0 Copay, then 0% Coinsurance	30% Coinsurance	\$0 Copay, then 0% Coinsurance
Fitness Centers – The Plan will contribute up to \$15 per month (to a maximum of \$180 per Plan Year) towards membership fees for those facilities approved by the Plan.				
Covered Vision Expenses – Vision examination limited to one (1) exam every twenty-four (24) months. Frames and prescription lenses or contacts limited to \$200 every twenty-four (24) months. If contact lenses are selected, no additional allowance will be made for other types of lenses and/or frames during that 24 month period.	\$0 Copay, then 0% Coinsurance	\$0 Copay, then 0% Coinsurance	\$0 Copay, then 0% Coinsurance	\$0 Copay, then 0% Coinsurance
Hospital Services				
Outpatient Surgery Facility	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Outpatient Laboratory/X-ray (includes independent facilities)	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Major Diagnostic Services	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Hospital (Inpatient & Outpatient)	\$100 Copay per admission, then 0% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Emergency Room Treatment	\$75 Copay, then 0% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Maternity Services				
Initial Office visit to determine pregnancy	\$20 Copay, then 0% Coinsurance	\$20 Copay, then 0% Coinsurance	30% Coinsurance	\$20 Copay, then 0% Coinsurance
Outpatient of Independent Lab/X-ray/ Ultrasounds	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Physician charges for Maternity related services – including non-routine prenatal and post natal visits	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance

Covered Medical Expenses:	Preferred Tier	Network	Non-Network	Out-of-Area
Other Covered Services				
Allergy Injections, Serums and Testing	20% Coinsurance	20% Coinsurance	30% Coinsurance	20% Coinsurance
Ambulance	20% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance
Acupuncture <ul style="list-style-type: none"> Maximum Benefit per Plan Year 	\$20 Copay, then 0% Coinsurance	\$20 Copay, then 0% Coinsurance	30% Coinsurance \$1,500	\$20 Copay, then 0% Coinsurance
Blood and Plasma	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Chemotherapy & Radiation	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Dialysis Note: If the Participant is eligible for Medicare, the Usual and Customary Fee for dialysis claims will be limited to 125% of Medicare's reimbursement level.	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Hospice Care	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Medical Supplies and Equipment	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Mental Health Disorders and Substance Abuse Conditions	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Hearing Aids – Covered for Children up to age 19	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Morbid Obesity	40% Coinsurance	50% Coinsurance	Not Covered	50% Coinsurance
Sterilization (Employee and Spouse)	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Temporomandibular Joint Dysfunction <ul style="list-style-type: none"> Non Trauma Lifetime Benefit Trauma Lifetime Benefit 	10% Coinsurance	10% Coinsurance	30% Coinsurance \$1,000 \$5,000	10% Coinsurance
Rehabilitation Services				
Cardiac and Pulmonary Rehabilitation	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Chiropractic Care <ul style="list-style-type: none"> Maximum Benefit per Plan Year 	\$20 Copay, then 0% Coinsurance	\$20 Copay, then 0% Coinsurance	30% Coinsurance \$1,500	\$20 Copay, then 0% Coinsurance
Home Health Care <ul style="list-style-type: none"> Maximum Visits per Plan Year 	10% Coinsurance	10% Coinsurance	30% Coinsurance 120 Visits	10% Coinsurance
Home IV Therapy	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
Physical, Speech and Occupational Therapy – Precertification is required after 12 visits <ul style="list-style-type: none"> Maximum Visits per Plan Year 	5% Coinsurance	10% Coinsurance	30% Coinsurance 60 Visits for each type of therapy	10% Coinsurance
Skilled Nursing Facility Services	10% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance
All other covered services	5% Coinsurance	10% Coinsurance	30% Coinsurance	10% Coinsurance

Summary of Dental Benefits

The following Deductibles, maximums and benefits are per Participant:

Plan Year Deductible	Network
<i>Combined for Medical and Dental benefits. The Plan Year Deductible must be satisfied before benefits payments are made for services indicated with a "Coinsurance" unless indicated otherwise. The Plan Year Deductible does not apply to services indicated with a "Copay"</i>	
Per Individual	\$500
Per Family Unit	\$1,000

Covered Dental Expenses:	Benefits
Class 1 Services (Preventive Care)	0% Coinsurance and Deductible waived
Class 2 Services (Repair and Restoration)	20% Coinsurance and Deductible applies
Class 3 Services (Major Dental Repair)	20% Coinsurance and Deductible applies
Class 4 Services (Orthodontics)	50% Coinsurance and Deductible Applies
<i>Charges are limited to Usual and Customary Fees.</i>	
Covered Dental Expenses:	Benefit Maximums
Class 1 Services (Preventive Care)	\$1,200 per Plan Year
Class 2 Services (Repair and Restoration)	
Class 3 Services (Major Dental Repair)	
Class 4 Services (Orthodontics)	\$1,200 per Lifetime

Summary of Prescription Drug Benefits

The following benefits are per Participant:

Benefit:	Participating Network Pharmacy
Plan Year Deductible Prescription	
• Individual	\$250
• Family Unit	\$500
Plan Year Out-of-Pocket Maximum	
• Individual	\$1,000
• Family Unit	\$2,000
Retail Prescription Drugs (30 day supply)	
• Generic Drug	0% Coinsurance
• Brand Name Drug	The lessor of \$150 copayment or 20% Coinsurance
Mail Order Prescription Drugs (90 day supply)	
• Generic Drug	0% Coinsurance
• Brand Name Drug	The lessor of \$150 copayment or 18% Coinsurance

ARTICLE V MEDICAL BENEFITS

Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Abortion.** Expenses Incurred directly or indirectly as the result of an abortion, limited to Medically Necessary;
2. **Acupuncture.** Acupuncture is covered when administered by a Doctor of Oriental Medicine or a licensed provider acting within the scope of licensure and when medically necessary for the treatment of an illness or injury. Benefits for acupuncture are limited as specified in the Schedule of Benefits.
3. **Allergy Services.** Charges related to the treatment of allergies;
4. **Ambulance.** Transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition, if the transportation is connected with an Inpatient confinement;
5. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;
6. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;
7. **Approved Cancer Clinical Trials, Patient Care Costs.** Payment is limited to in-state or Network cost. Does not cover:
 - Cost of an investigational drug, device, or procedure.
 - Costs of non-health care services that the patient needs because of clinical trial participation.
 - Costs associated with managing the research that is part of the clinical trial.
 - Costs that would not be covered by the patient's health plan if standard treatments were provided.
 - Costs of extra tests that would not be done except for participation in the clinical trial.
 - Cost paid or not charged for by the clinical trial providers.
8. **Birthing Center.** Services of a birthing center for Medically Necessary care provided within the scope of its license;
9. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank;
10. **Chemotherapy.** Charges for chemotherapy/radiation;
11. **Chiropractic Care.** Spinal adjustment and manipulation, x rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Benefits;
12. **Dental.** Emergency repair due to Injury to sound natural teeth, if the repair is made within 12 months from the date of the Injury (unless otherwise required by applicable law);
13. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, and other diagnostic tests and procedures;
14. **Diabetes Education.** Expenses incurred for diabetes education, limited to 8 visits per Plan Year;

15. Diabetes – Active Care Diabetes Program:

- a. The Plan will provide 100% reimbursement/payment for diabetes testing/supplies and services only through the Preferred Diabetes Treatment Plan managed by the Active Care Diabetes Program. Members will not have any co-pay, co-insurance or Deductible through this exclusive program. However, the Plan will not reimburse members or pay for diabetes treatment/services or supplies obtained from any other vendor, provider, pharmacy, or supplier. Members who utilize an insulin pump where the pump and glucometers communicate wirelessly and the glucometer manages the amount of insulin dispensed by the pump are an exception. Participation in the Preferred Diabetes Treatment Program is voluntary.
- b. Members and their Dependents that choose to participate in the Preferred Diabetes Treatment Plan will receive the following enhanced coverage for diabetes testing supplies:
 - i. Diabetes supplies provided through the ActiveCare Diabetes Program, the Preferred Treatment Plan for those Participants that are diagnosed with diabetes. These supplies may include:
 - 1) Cellular Glucose meter;
 - 2) Diabetes testing strips;
 - 3) Control solution;
 - 4) Alcohol Swabs;
 - 5) Lancets;
 - 6) Lancing device(s);
 - 7) An uplink hub that is paired with one or more Bluetooth enabled medical devices, which, upon open access Wi-Fi networks or the onboard GSM/CDMA dual network SIM care for the uploading of member’s biometric measurements;
 - 8) A Bluetooth enabled weight scale, which captures:
 - a) Date;
 - b) Time of Day; and
 - c) Weight measurement in Imperial or Metric units;
 - 9) A Bluetooth enabled blood pressure cuff, which captures:
 - a) Date;
 - b) Time of Day;
 - c) Systolic pressure readings; and
 - d) Diastolic pressure readings;
 - ii. As part of the Preferred Diabetes Treatment Plan, Plan members/Participants will have access to their personal health information collected by Active Care within the scope of the Diabetes Program. This access will be provided via a HIPAA compliant web portal, requiring an individual-specific User ID and Password.
 - iii. The Service includes:
 - 1) Blood Glucose Readings Tab – this information may include, but is not limited to the following:
 - a) Average blood glucose level over the past 90 days;
 - b) Dynamic blood glucose reading graph, which displays blood glucose readings for today, or for the past 7 days, 30 days, 90 days, or the duration of the member’s participation in the Preferred Diabetes Treatment Plan;

- c) Within the dynamic blood glucose readings graph, the date, the time and activity associated with the blood glucose test can be displayed, so long as the Participant selected an activity from the selection menu on the glucometer, at the time of the test;
- d) Number of tests within the past 90 days and the corresponding risk factor associated with each test;
- e) The Average Blood Glucose level over the past 7 days, 14 days and 30 days;
- f) “My Goals” section representing the Average Blood Glucose level over the past 7 days, 14 days and 30 days that a participating member has targeted as their desire goal to achieve;
- g) HbA1c chart provided through the American Diabetes Association, which correlates average glucose levels to corresponding HbA1c levels;
- h) Recent History section, which allows participating members to make specific relevant notes regarding individual blood glucose readings, which add context to the reading;

2) Test Frequency Tab

- a) Dynamic daily testing frequency graph, which displays blood glucose readings for variable timeframes;

3) Weight Scale Tab – this information may include, but is not limited to the following:

- a) Dynamic weight scale readings graph, which displays weight in Imperial pounds for today, or for the past 7 days, 30 days, 90 days, or the duration of the member’s participation in the Preferred Treatment Plan;
- b) Within the dynamic weight scale readings graph, the date and weight are displayed;
- c) Recent History section, which allows participating members to make specific, relevant notes regarding individual weight readings, which add context to the reading;

4) Blood Pressure Readings Tab – this information may include, but is not limited to the following:

- a) Dynamic blood pressure reading graph, which displays blood pressure and heart rate readings for today, or for the past 7 days, 30 days, 90 days, or the duration of the member’s participation in the Preferred Treatment Plan;
- b) Within the dynamic blood pressure readings graph, the date, time and activity associated with the blood pressure test are displayed in blue, while the heart rate graph is displayed in green;
- c) Recent History section, which allows participating members to make specific, relevant notes regarding individual blood pressure or heart rate readings, which add context to the reading;

16. **Dialysis.** If you are diagnosed with a condition requiring dialysis, you may be able to enroll in Medicare. Upon beginning dialysis treatments, Medicare, if applicable, will coordinate benefits with the Plan as the secondary payor for months 4 through 33 of the coordination period while you are receiving dialysis treatments. Prior to month 4, your health plan pays as indicated in the Summary of Medical Benefits. Beginning month 4 of your dialysis treatment, your dialysis benefit will be covered and paid above the Medicare payment levels. When dialysis benefits are payable under this Plan, the Usual and Customary Fee for dialysis claims will be limited to 125% of Medicare’s reimbursement level. The Plan will not enroll you in Medicare; it is your decision and your responsibility to enroll in Medicare, if applicable.

In order for us to coordinate your Plan benefits with Medicare coverage, we are hereby requiring you to follow the following steps:

- a. Notify Caprock HealthPlans when you are diagnosed with end stage renal disease (ESRD) by your doctor;
- b. Notify Caprock HealthPlans if or when you begin to receive dialysis treatments;
- c. Notify Caprock HealthPlans and send copy of your Medicare card when enrolled in Medicare.

17. **Durable Medical Equipment.** Subject to all of the following:

- a. The equipment must meet the definition of Durable Medical Equipment. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds, and oxygen equipment.
- b. The equipment must be prescribed by a physician.
- c. The equipment is subject to review under the Utilization Management, if applicable.
- d. The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- e. The Plan will pay benefits for only one of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless repair or replacement is due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- f. If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries or replacement only if required:
 - due to the growth or development of a dependent child;
 - when necessary because of a change in the Participant's physical condition; or
 - because of deterioration caused from normal wear and tear.

18. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist (excluding routine foot care);

19. **Glaucoma.** Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type);

20. **Gleevec.** Gleevec, for treatment of any of the following conditions:

- a. CML myeloid blast crisis;
- b. CML accelerated phase; or
- c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patients' Physician including the condition being treated must be submitted to the Plan;

21. **Hearing Aids.** Hearing aids and examinations for the prescription or fitting of hearing aids is covered for Children up to age 19.

22. **Home Health Care.** Charges by a Home Health Care Agency:

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

NOTE: Transportation services are not covered under this benefit;

23. **Hospice Care.** Charges relating to Hospice Care, provided the Participant has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Summary of Benefits. Covered Hospice expenses are limited to:
- a. Room and Board for confinement in a Hospice;
 - b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
 - c. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
 - d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
 - e. Home health aide services;
 - f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
 - g. Medical social services by licensed or trained social workers, Psychologists or counselors;
 - h. Nutrition services provided by a licensed dietitian;
 - i. Respite care; and
 - j. Bereavement counseling, which is a supportive service provided by the Hospice team to Participants in the deceased's family after the death of the terminally ill person, to assist the Participants in adjusting to the death. Benefits will be payable up to 6 visits per family if the following requirements are met:
 - i. On the date immediately before his or her death, the terminally ill person was in a Hospice Care Program and a Participant under the Plan; and
 - ii. Charges for such services are Incurred by the Participants within 6 months of the terminally ill person's death.

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

24. **Hospital.** Charges made by a Hospital for:

- a. Inpatient Treatment
 - i. Daily semi private Room and Board charges;
 - ii. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
 - iii. General nursing services; and
 - iv. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board
 - b. Outpatient Treatment
 - i. Emergency room;
 - ii. Treatment for chronic conditions;
 - iii. Physical therapy treatments;
 - iv. Hemodialysis; and
 - v. X ray, laboratory and linear therapy;
25. **Mastectomy.** The Federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The new Federal law requires group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

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

- a. Reconstruction of the breast on which the Mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Protheses and physical complications from all stages of Mastectomy, including lymphedemas; in a manner determined in consultation with the attending Physician and the patient.

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

- 26. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes;
- 27. **Newborn Care.** Hospital and Physician nursery care for newborns who are natural Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage and the Child's own Deductible and coinsurance provisions will apply.
 - a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth; and
 - b. The following Physician services for well-baby care during the Newborn's initial Hospital confinement at birth:
 - i. The initial newborn examination and a second examination performed prior to discharge from the Hospital; and
 - ii. Circumcision.

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

- 28. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse;
- 29. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing outpatient facility;
- 30. **Oral Surgery.** Oral surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist;
- 31. **Osseous Surgery.** Charges for osseous surgery;
- 32. **Pathology Services.** Charges for pathology services;
- 33. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free standing duly licensed Outpatient therapy facility;
- 34. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital outpatient visits and exams, clinic care and surgical opinion consultations;
- 35. **Pregnancy Expenses.** Dependent Children are eligible for coverage for any expenses in connection with Pregnancy and delivery.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's

attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an “attending Provider” include a plan, Hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or Surgical care of an Illness, shown in the “Summary of Benefits” and this section, and subject to the same maximums;

36. **Preventive Care.** Charges for Preventive Care services.

Benefits mandated through the PPACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See <http://www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm> or <https://www.healthcare.gov/prevention> for more details.

Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider of care to determine which services to provide;

Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: <http://www.healthcare.gov/law/about/provisions/services/lists.html>

Women’s Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA’s Women’s Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women’s services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling

A description of Women’s Preventive Services can be found at: <http://www.healthcare.gov/news/factsheets/2011/08/womensprevention08012011a.html>

37. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices, but excluding orthopedic shoes and other supportive devices for the feet;
38. **Radiation Therapy.** Charges for radiation therapy and treatment;
39. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;
40. **Routine Physical Examinations.** Routine physical examinations specifically in the following instances: sports or sports camp physicals, immunizations or medication required for international travel and Hepatitis B immunizations when required due to possible exposure during the Participant's work;
41. **Second Surgical Opinions.** Charges for second surgical opinions;
42. **Skilled Nursing Facility.** Charges made by a skilled nursing facility or a convalescent care facility, up to the limits set forth in the Summary of Benefits, in connection with convalescence from an Illness or Injury (excluding Drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Participant is confined;
43. **Speech Therapy.** Speech therapy by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders;
44. **Sterilization.** Charges related to sterilization procedures;
45. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 - a. Multiple procedures adding significant time or complexity will be allowed at:
 - i. 100% of the full Usual and Customary Fee value for the first or major procedure;
 - ii. 50% of the Usual and Customary Fee value for the secondary and subsequent procedures;
 - iii. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of Usual and Customary Fee value for the major procedure, and 50% of the Usual and Customary Fee value for the secondary or lesser procedure;
 - b. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual and Customary Fee value for the type of Surgery performed;
 - c. No benefit will be payable for incidental procedures, such as appendectomy during an abdominal Surgery, performed during a single operative session;
46. **Surgical Treatment of Jaw.** Surgical treatment of Diseases, Injuries, fractures and dislocations of the jaw by a Physician or Dentist;
47. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:
 - a. Bone marrow;
 - b. Heart;
 - c. Lung;
 - d. Heart and lung;
 - e. Liver;

- f. Pancreas;
- g. Kidney; and
- h. Cornea.

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

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

- a. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- b. Services and supplies furnished by a Provider; and
- c. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs, including donor medical expenses, directly related to the procurement of an organ or tissue used in a transplant described herein will be covered for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

Psychiatric and Substance Abuse Benefits

Inpatient Benefits

The Plan will pay Covered Expenses for:

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

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

Outpatient Benefits

The Plan will pay Covered Expenses for:

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

ARTICLE VI MEDICAL EXCLUSIONS AND LIMITATIONS

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

1. **Abortion.** Expenses incurred directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise, limited to Medically Necessary;
2. **Biofeedback.** Biofeedback;
3. **Chelation Therapy.** Chelation therapy except for heavy metal or lead poisoning;
4. **Consultations.** Consultations for non-covered services, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
5. **Contraceptives.** Prescription contraceptives and contraceptive devices.
6. **Cosmetic Surgery.** Charges for Cosmetic Surgery except for treatment necessitated by accidental injury, correction of a congenital malformation of a dependent child, or breast reduction in connection with a mastectomy as specifically provided under Covered Medical Benefits;
7. **Counseling or Training.** Counseling or training that is associated with: behavior, social maladjustment, lack of discipline, learning disabilities, developmental delays, other antisocial actions, marriage, family, sex or other reasons that are not specifically the result of a Mental Health Condition;
8. **Custodial Care.** Custodial Care, domiciliary care or rest cures, or Home Health Care except as specifically provided herein;
9. **Education or Training Program.** Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
10. **Eye Refractions.** Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury or as shown in the Schedule of Benefits);
11. **Hair Pieces.** Wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness except for wigs or artificial hair pieces will be covered for hair loss as a result of a chemotherapy or radiation treatment up to a maximum of \$150 per lifetime;
12. **Hearing Devices.** Hearing aids or examinations for the prescription or fitting of hearing aids are not covered for adults age 19 and older;
13. **Homeopathy or Naturopathy.** Homeopathy or naturopathy; holistic or homeopathic medicine, massage therapy or rolfing;
14. **Hypnosis.** Expenses related to the use of hypnosis;
15. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother, donor eggs; therapeutic injections and surgical reversal of elective sterilization;

16. **Oral Surgery.** Oral surgery or dental treatment, except as specifically provided in the Plan;
17. **Organ Transplants.** Expenses related to donation of a human organ or tissue, except as specifically provided;
18. **Orthopedic Shoes.** Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet;
19. **Personal Convenience Items.** Equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician;
20. **Private Duty Nursing.** Private duty nursing (outpatient only).
21. **Radial Keratotomy.** Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses including lasik, keratotomy or other eye Surgery to correct near or far sightedness or complication thereof;
22. **Routine Foot Care.** Routine or periodic examinations in the absence of systematic disease treatment for weak, unstable or flat feet, or bunions unless an open cutting operation is performed or the removal of corns or calluses or trimming of toenails, unless at least part of the nail root is removed;
23. **Routine Physical Examinations.** Routine or periodic physical examinations including employment physicals, insurance examinations or examinations at the request of a third part, premarital examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits
24. **Sex Change Operation.** Expenses related to a sex change operation or treatment of sexual dysfunction not related to organic Disease;
25. **Travel.** Travel, whether or not recommended by a Physician, except as specifically provided herein; and
26. **Vitamins.** Vitamins.

**ARTICLE VII
DENTAL BENEFITS**

Plan Year Deductible	Network
<i>Combined for Medical and Dental benefits. The Plan Year Deductible must be satisfied before benefits payments are made for services indicated with a "Coinsurance" unless indicated otherwise. The Plan Year Deductible does not apply to services indicated with a "Copay"</i>	
Per Individual	\$500
Per Family Unit	\$1,0000

Covered Dental Expenses:	Benefits
Class 1 Services (Preventive Care)	0% Coinsurance and Deductible waived
Class 2 Services (Repair and Restoration)	20% Coinsurance and Deductible applies
Class 3 Services (Major Dental Repair)	20% Coinsurance and Deductible applies
Class 4 Services (Orthodontics)	50% Coinsurance and Deductible Applies
<i>Charges are limited to Usual and Customary Fees.</i>	
Covered Dental Expenses:	Benefit Maximums
Class 1 Services (Preventive Care)	\$1,200 per Plan Year
Class 2 Services (Repair and Restoration)	
Class 3 Services (Major Dental Repair)	
Class 4 Services (Orthodontics)	\$1,200 per Lifetime

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Plan Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this Article. Covered Expenses Incurred by any Participant and Family Unit in the last three months of any Plan Year which are applied to satisfy the Deductible for that Plan Year/Calendar Year may also be used toward satisfaction of the Deductible in the next Plan Year.

Waiting Periods for Dental Services

No charges for Expenses Incurred for Class 3 (Major) or Class 4 (Orthodontia) will be paid under the Participant has been covered under this Plan for six (6) months.

Covered Expenses

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

Class 1 Services (Preventive Care)

1. Routine oral examinations and prophylaxis (cleaning, scaling and polishing teeth), but not more than two times per Plan Year;
2. Periapical x-rays, as required, and bitewing x rays not more than two times per Plan Year;
3. Full mouth x rays, but not more than once in a 3 year period;
4. Panoramic x rays, but not more than once in a 3 year period;
5. Sealants for Dependent Children under age 14, but not more than once in any period of 3 years; and
6. Topical application of fluoride for Dependent Children under age 19, but not more than once per Plan Year.

Class 2 Services (Basic)

1. All Medically Necessary x-rays;
2. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore Diseased or accidentally broken teeth. Gold foil restorations are not eligible;
3. Simple extractions;
4. Extraction of one or more teeth;

5. Cutting procedures in the mouth;
6. Dislocations of the jaw, but not including additional charges for removal of stitches or post-operative examinations;
7. Treatment of the gums and supporting structure of the teeth including osseous surgery, gingivectomies, grafts, scaling and root planning;
8. Injectable antibiotics administered by a dentist;
9. Medicines legally obtainable only upon written prescription by a dentist;
10. Nitrous oxide only for an individual who has not attained age seven (7);
11. Laboratory examinations and tests;
12. Endodontics, including pulpotomy, direct pulp capping and root canal treatment;
13. Anesthetic services, except local infiltration or block anesthetics, performed by, or under the direct personal supervision of, and billed for by a Dentist, other than the operating Dentist or his or her assistant;
14. Periodontal examinations, treatment and surgery;
15. Consultations;
16. Space maintainers (not made of precious metals) that replace prematurely lost teeth for Dependent Children under age 19. No payment will be made for duplicate space maintainers; and
17. Palliative Emergency treatment of an acute condition requiring immediate care.

Class 3 Services (Major Dental Repair)

Prosthetic services (initial installation or replacement of bridgework or dentures) will be covered only when a Participant has been covered continuously for at least 6 months, unless otherwise required by applicable law.

1. Gold fillings (including inlays and onlays) and crowns necessary to restore the structure of teeth broken down by decay or injury, except that: (1) the benefit for a crown or gold filling will be limited to the charge for a silver, porcelain, or other filling unless the tooth cannot be restored with such other material; and (2) the replacement if a crown or gold filling is covered only if the crown or filling is over five (5) years old;
2. Repair or recementing of crowns, inlays, bridgework or dentures and relining of dentures;
3. Unless otherwise required by applicable law, replacement of an existing denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or bridgework, to replace one or more natural teeth:
 - a. Where the existing denture or bridgework was installed at least five years prior to its replacement and it cannot be made serviceable; or
 - b. Where the existing denture is an immediate temporary denture, and necessary replacement by the permanent denture takes place within 6 months;
4. Re-lines;
5. Post and core;
6. Stainless steel crowns.

Class 4 Services (Orthodontics)

Orthodontic services will be eligible for all Participants.

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

ARTICLE VIII DENTAL EXCLUSIONS AND LIMITATIONS

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

1. **Adjustments.** Charges for services to alter vertical dimension (work done or appliance used to increase the distance between nose and chin); to restore or maintain occlusion (work done or appliance used to change the way the top and bottom teeth meet or mesh); to replace tooth structure lost as a result of abrasion or attrition; for splinting; or for treatment of disturbances of the temporomandibular joint;
2. **Administrative Costs.** For administrative costs of completing claim forms or reports or for providing dental records;
3. **After the Termination Date.** The Plan will not pay for services or supplies furnished after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date. However, benefits for covered dental expenses Incurred for the following procedures will be payable as though the coverage had continued in force:
 - a. A prosthetic device, such as full or partial dentures, if the Dentist took the impression and prepared the abutment teeth while the patient was a Participant in the Plan, and delivers and installs the device within two months following termination of coverage;
 - b. A crown, if the Dentist prepared the tooth for the crown while the patient was a Participant in the Plan, and installs the crown within two months following termination of coverage; and
 - c. Root canal therapy if the Dentist opened the tooth while the patient was a Participant in the Plan, and completes the treatment within two months following termination of coverage;
4. **Athletic Mouthguards;**
5. **Broken Appointments.** For charges for broken or missed dental appointments;
6. **Cosmetic.** Charges for cosmetic dental work. This includes, but is not limited to, characterization of dentures and services to correct congenital or developmental malformations. This exclusion will not apply to cosmetic work needed as a result of Accidental Injuries, but damage resulting from biting or chewing is not considered an Accidental Injury. This exclusion also does not apply to covered Orthodontic Treatment;
7. **Education.** Charges for instruction in oral hygiene, plaque control or diet;
8. **Excess Charges.** Charges in excess of the Reasonable Charge for the service or supply received or charges in excess of any maximum payable under this Plan;
9. **Experimental.** Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association;
10. **Government Provided.** Charges for dental care paid for or provided by the laws of any government or treatment given in a government-owned facility, unless the Employee or Dependent is legally required to pay;
11. **Hygiene.** For oral hygiene, plaque control programs or dietary instructions;
12. **Immediate Relative.** Services rendered by a person who is an immediate relative of, or who ordinarily resides with, the Participant requiring treatment. “Immediate relative” means spouse, Child, brother, sister or parent of the Participant, whether by birth, adoption or marriage;

13. **Implants.** For implants, including any appliances and/or crowns and the surgical insertion or removal of implants except, first-time non-cosmetic dental implants;
14. **Late Enrollee.** Charges for crowns, bridgework, dentures, periodontics and orthodontics Incurred during the first 24 months of coverage for a Late Enrollee, unless such services and supplies are needed as a result of Accidental Injury sustained by the Participant. (Damage resulting from biting or chewing is not considered an Accidental Injury.) “Late enrollee” means a person who enrolls for coverage during an annual enrollment period because he or she failed to enroll when first eligible for coverage or during a special enrollment period. Waiting periods for Dental Services are as follows: No charges for Expenses Incurred for Class 3 (Major) or Class 4 (Orthodontia) will be paid until the Participant has been covered under this Plan for six (6) months;
15. **Miscellaneous.** The Plan does not cover any charge, service or supply which is:
- a. For treatment other than by a Dentist or Physician, except:
 - i. Cleaning, scaling and application of fluoride performed by a licensed dental hygienist under the supervision of a Dentist; and
 - ii. Non-Experimental services performed at a dental school under the supervision of a Dentist, if the school customarily charges patients for its services;
 - b. For local infiltration anesthetic when billed for separately by a Dentist;
 - c. For personalization or characterization of dentures or veneers or any cosmetic procedure or supplies;
 - d. For oral hygiene or dietary instructions;
 - e. For a plaque control program (a series of instructions on the care of the teeth);
 - f. For implants, including any appliances and/or crowns and the surgical insertion or removal of implants;
 - g. For periodontal splinting;
 - h. For consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form;
 - i. For substances or agents which are administered to minimize fear, or charges for analgesia, unless the patient is handicapped by cerebral palsy, mental retardation or spastic disorder;
 - j. For replacement of a lost, missing or stolen prosthetic device;
 - k. Not equal to accepted standards of dental practice, including charges for services or supplies which are Experimental;
 - l. Paid, payable or required to be provided under any no-fault or equivalent automobile insurance law. Any uninsured motorist will be considered to be self-insured;
 - m. Charges for missed appointments or completion of claim forms;
 - n. Covered under the “Medical Benefits” Article of the Plan; and
 - o. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein;
16. **Missing Appliances.** Charges for replacement of lost, missing or stolen appliances or prosthetic devices;
17. **More Expensive Course of Treatment.** In all cases involving covered services in which the Provider and the Participant select a more expensive course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned, coverage under the Plan will be based upon the charge allowed for the lesser procedure;
18. **Myofunctional therapy;**
19. **No Coverage.** Services or supplies for which charges are Incurred at a time when no coverage is in force for that person, or for which charges are Incurred while coverage is in force, but final delivery is made more than 3 months after the date coverage for that person terminated;
20. **No Legal Obligation.** Charges for which the person has no legal obligation to pay, or for which no charge would be made in the absence of a treatment plan;

21. **No Listing.** For services which are not included in the list of covered dental services;
22. **Not Necessary.** Charges for unnecessary care, treatment, services or supplies, including replacement at any time of a bridge or denture which meets or can be made to meet commonly held dental standards of functional acceptability;
23. **Not Recommended.** Charges for services or supplies which are not recommended and approved by a Dentist or Physician;
24. **Occupational.** Charges for dental care which results from any employment, if covered to any extent by workers' compensation or similar law;
25. **Orthognathic Surgery.** For Surgery to correct malpositions in the bones of the jaw;
26. **Personalization.** For expenses for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures;
27. **Sealants.** Sealants except as indicated under the Covered Dental Services;
28. **Self-inflicted.** Charges for care, treatment, services and supplies needed as a result of intentionally self-inflicted Injury or Sickness;
29. **Single Provider Care.** In the event a Participant transfers from the care of one Provider to that of another during a course of treatment, or if more than one Provider performs services for one or more dental procedures, the Plan shall consider only such expense as would be appropriate had a single Provider performed the service. An appropriate expense in this case will be the Usual and Customary Fee;
30. **Splinting.** For crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic; and
31. **War/Riot.** Charges for services or supplies needed as a result of war, declared or undeclared, or any act of war or act of aggression by any country; or voluntary participation in a riot.

Pre-determination of Dental Benefits

If a Participant's proposed course of treatment reasonably can be expected to involve dental charges of \$200 or more, a description of the procedures to be performed and an estimate of the charges therefore may be filed with the Plan Administrator or Third Party Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre determination of dental benefits is provided only as a convenience to the Participant.

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

ARTICLE IX PRESCRIPTION DRUG BENEFITS

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

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

The copayment is applied to each charge and is shown on the Summary of Benefits, above.

Covered Expenses

The following are covered under the Plan:

1. **Bee Sting Kits.** Charges for EPI PEN and Ana Kit;
2. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
3. **Diabetes.** Insulins, insulin syringes and needles, when prescribed by a Physician;
4. **Gleevec.** Gleevec, for treatment of any of the following conditions:
 - a. CML myeloid blast crisis;
 - b. CML accelerated phase; or
 - c. CML in chronic phase after failure of interferon treatment;

Prior authorization is required. In order to obtain such authorization, information from the patient’s Physician indicating the condition being treated must be submitted to the Plan.

5. **Legend Drugs.**
 - a. Class V Drugs;
 - b. Diagnostics; and
 - c. Pre-natal vitamins;
6. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below;

Limitations

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

1. **Dosages.**
 - a. With respect to the Pharmacy Option, any one prescription is limited to the greater of a 30 day supply; and
 - b. With respect to the Mail Order Option, any one prescription is limited to the greater of a 90 day supply.
2. **Refills.**
 - a. Refills only up to the number of times specified by a Physician; and
 - b. Refills up to one year from the date of order by a Physician.

ARTICLE X PRESCRIPTION DRUG EXCLUSIONS

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

1. **Acne Control and Cosmetic Anti-Aging.** Accutane and Retin-A, except for under age 19;
2. **Administration.** Any charge for the administration of a covered Drug;
3. **Allergy Sera.** Charges for allergy sera;
4. **Anorexiant.** Anorexiant (weight loss Drugs);
5. **Blood and Blood Plasma.** Charges for blood and blood plasma;
6. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;
7. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device;
8. **Excluded Items.** Any charge excluded under the Articles entitled “General Limitations and Exclusions,” or “Summary of Benefits;”
9. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant;
10. **Fertility Agents.** Charges for fertility agents;
11. **Growth Hormones.** Charges for growth hormones, except for under age 16;
12. **Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector);
13. **Immunizations.** Immunization agents or biological sera;
14. **Immunologicals.** Charges for Immunologicals (vaccines);
15. **Impotency.** A charge for impotency medication, including Viagra;
16. **Injectables.** A charge for injectables;
17. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;
18. **Investigational Use Drugs.** A Drug or medicine labeled “Caution – limited by Federal law to Investigational use;”
19. **Legend Drugs.**
 - a. Legend Drugs with over the counter equivalents; and
 - b. Vitamins;
20. **Medical Devices and Supplies.** Charges for legend and over the counter medical devices and supplies;

21. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;
22. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;
23. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;
24. **Over-the-counter Drugs.** Charges for over the counter Drugs:
 - a. Class V Drugs;
 - b. Diagnostics;
 - c. Pre natal vitamins; and
 - d. Vitamins;
25. **Rogaine.** Charges for Rogaine (topical minoxidil);
26. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches and treatment to eliminate or reduce a dependency on or addition to tobacco except as specifically provided under the Covered Medical Benefits – Prescription Drugs;
27. **Steroids.** Anabolic steroids except under age 16 if Medically Necessary; and
28. **Vitamins.** Vitamins, except pre-natal vitamins.

ARTICLE XI ELIGIBILITY FOR COVERAGE;

Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 30 days, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan. If employment is terminated and the Employee returns to Active Employment within 30 days from the date of termination, the Service Waiting Period will be waived and coverage will take effect on the first day the Employee returns to Active Employment. If coverage is terminated due to non-payment of premium during an Employer approved leave of absence and the employee returns to work within 30 days from the date of coverage terminated, the Service Waiting Period will be waived and coverage will take effect of the first day the Employee returns to Active Employment. The deductible, out-of-pocket expenses satisfied prior to the termination of coverage will be applied upon the employee's coverage reinstatement.

Rehired Employees who have continued coverage under COBRA shall not be required to satisfy the Service Waiting Period.

Eligibility Dates for Dependent Coverage

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

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

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

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

Effective Dates of Coverage; Conditions

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

1. Enrollment Form. Coverage for an Employee or his or her Dependents must be requested by the Employee on a form furnished by the Plan Administrator and will become effective on the date such Employee or Dependents are eligible, provided the Employee has enrolled for such coverage on a form satisfactory to the Plan Administrator within the 30 day period immediately following the date of eligibility.
2. Birth of Dependent Child. If a Dependent Child is born after the date the Employee's coverage for himself or herself under the Plan becomes effective and the Employee has coverage under this Plan for his or her Dependents, coverage shall take effect from and after the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child. Such coverage shall continue for the 30 day period commencing on the date of birth. In order to continue such coverage after the 30th day, prior to the end of the 30 day period, the Employee must make written application to the Plan for such Child and agree to make any required contribution.

If the Employee does not have coverage under this Plan for any Dependents at the date of such Child's birth, then coverage for such Child shall be available only if, during the first 30 days following the date of birth, the Employee makes written application to the Plan for such Child and agrees to make any required contribution. In that event, coverage will be effective as of the moment of birth, to the extent of the benefits provided herein, and any limitations of this Plan with respect to congenital defects shall not apply to such Child.

3. Newly Acquired Dependents. If an Employee acquires a Dependent while the Employee is eligible for coverage for Dependents, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible, provided application is made to the Plan within 30 days of the date of eligibility and any required contributions are made.
4. Requirement for Employee Coverage. No coverage for Dependents of an Employee will become effective unless the Employee is, or simultaneously becomes, eligible for coverage for himself or herself under the Plan.
5. Coverage as Both Employee and Dependent. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

Special and Open Enrollment

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

Loss of Other Coverage

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

The following conditions apply to any eligible Employee and Dependents:

An Employee may enroll during this special enrollment period:

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

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

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

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

New Dependent

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her Dependents during a special enrollment period. The Employee must make written application for special enrollment no later than 30 days after he or she acquires the new Dependent. The following conditions apply to any eligible Employee and Dependents:

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

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

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

1. For a marriage, on the date of the marriage;
2. For a birth, on the date of birth; or
3. For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

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

Open Enrollment

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

“Open Enrollment Period” shall mean the month of July in each Plan Year.

Effective Date of Coverage; Conditions

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

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

“Alternate Recipient” shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

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

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

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

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

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

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

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

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

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

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

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

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

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

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

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

Acquired Companies

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

Genetic Information Nondiscrimination Act "GINA"

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

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

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

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

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

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

ARTICLE XII TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

Subject to a qualifying event, the coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan;
2. The fifteenth of the month for Employees who request that such coverage be terminated between the first (1st) and fifteenth (15th) day of the month. The last day of the month for Employees who terminate employment with the Employer between the sixteenth (16th) and the last day of the month;
3. The fifteenth of the month for Employees who fail to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing between the first (1st) and the fifteenth (15th) day of the month. The last day of the month for employees who fail to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing between the sixteenth (16th) and the last day of the month;
4. The date of the month in which he or she ceases to be eligible for such coverage under the Plan;
5. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

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

1. The date of termination of the Plan;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such inability;
 - b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; or
 - c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person ceases to be a Dependent, as defined herein, except as may be provided for in other areas of this section; or
7. Immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Rescission of Coverage

Coverage under this Plan may be rescinded under certain circumstances. A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a thirty (30) day notice period as described under Health Care Reform and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the thirty (30) day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Certificates of Coverage

The Plan generally will automatically provide a Certificate of Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is or has been covered under the Plan.

ARTICLE XIII CONTINUATION OF COVERAGE

Continuation During Family and Medical Leave Act (FMLA) Leave

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

Family and Medical Leave Act of 1993 (FMLA)

This applies to Employers with 50 or more Employees for at least 20 workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Covered Service Member

“Covered Service Member” shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee

“Eligible Employee” shall mean an individual who has been employed by **City of Carlsbad** for at least 12 months, has performed at least 1250 hours of service during the previous 12 month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member

“Family Member” shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18 years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Illness or Injury (of a service member of covered veteran)

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

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

Basic Leave Entitlement

FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to Pregnancy, prenatal medical care or Child birth;
2. to care for the Employee's Child after birth, or placement for adoption or foster care;
3. to care for the Employee's spouse, son, daughter or parent, who has a serious health condition; or
4. for a serious health condition that makes the Employee unable to perform the Employee's job.

Military Family Leave Entitlements

Eligible Employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is:

(1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of “serious Injury or Illness” for current service members and veterans are distinct from the FMLA definition of “serious health condition.”**

Benefits and Protections

During FMLA Leave, the Employer must maintain the Employee’s health coverage under any “group health plan” on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee’s leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered Employer for at least 12 months, have 1,250 hours of service in the previous 12 months, and if at least 50 Employees are employed by the Employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care Provider or one visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer’s normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA Leave when the need is foreseeable. When 30 days notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer’s normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave.

Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any Employer to:

1. interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:

1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627

WWW.WAGEHOUR.DOL.GOV

U.S. Department of Labor Wage and Hour Division

WHD Publication 1420 · Revised February 2013

Continuation During USERRA

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

Continuation During COBRA – Introduction

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

COBRA Continuation Coverage

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

Qualifying Events

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

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

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

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

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

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

1. The parent-covered Employee dies;
2. The parent-covered Employee’s hours of employment are reduced;
3. The parent-covered Employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced; or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

If a proceeding in bankruptcy is filed with respect to **City of Carlsbad**, and that bankruptcy results in the loss of coverage of any retired Employee, spouse, surviving spouse, and Dependent children covered under the Plan, such member will become a Qualified Participant with respect to the bankruptcy.

Employer Notice of Qualifying Events

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

Employee Notice of Qualifying Events

Each covered Employee or Qualified Participant is responsible for providing the COBRA Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual’s ceasing to be eligible as a Dependent Child under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Participant has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Participant entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and
5. Notice that a Qualified Participant, with respect to whom a notice described above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The COBRA Administrator is:

Caprock HealthPlans
4401 82nd Street Suite 1200
Lubbock, TX 79424
Phone: 806-783-9995
Fax: 806-783-9991
Website: www.caprockhp.com

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for providing the notice

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

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

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

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

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

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

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

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

Who Can Provide the Notice

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

Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Participant or loss of disability status);
4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Participant, name and address of the disabled Qualified Participant, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Participant who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

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

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

Electing COBRA Continuation Coverage

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

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

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

Duration of COBRA Continuation Coverage

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

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee’s (or former Employee’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child’s losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee’s hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Participants other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee’s hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage

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

Second Qualifying Event Extension of COBRA Continuation Coverage

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

Shorter Duration of COBRA Continuation Coverage

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

1. The date the Employer ceases to provide a group health plan to any Employee;
2. The date on which coverage ceases by reason of the Qualified Participant’s failure to make timely payment of any required contributions or premium;

3. The date that the Qualified Participant first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). However, a Qualified Participant who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-Existing condition or to the COBRA maximum time period, if less (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act); or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Participant is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Contribution and/or Premium Requirements

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

Additional Information

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

Caprock HealthPlans
4401 82nd Street Suite 1200
Lubbock, TX 79424
Phone: 806-783-9995
Fax: 806-783-9991
Website: www.caprockhp.com

Current Addresses

In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who is identified above) informed of any changes in the addresses of family members.

ARTICLE XIV GENERAL LIMITATIONS AND EXCLUSIONS

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

Alcohol. To a Participant, arising from taking part in any activity made illegal due to the use of alcohol. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Cosmetic Surgery. Charges for Cosmetic Surgery except for treatment necessitated by accidental injury, correction of a congenital malformation of a dependent child, or breast reconstruction in connection with mastectomy as specifically provided under Covered Medical Benefits;

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

Deductible Applicable. That are not payable due to the application of any specified Deductible provisions contained herein;

Error. That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

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

Experimental. That are Experimental or Investigational;

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

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

Government-Operated Facilities.

1. Services furnished to the Participant in any veterans Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. Services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law;

Illegal Acts. For any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Incurred by Other Persons. For expenses actually Incurred by other persons;

Ineligible Procedure. Incurred due to an ineligible procedure;

Medical Necessity. That are not Medically Necessary;

Medicare. For benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled “Coordination of Benefits” and “Medicare;”

Military Service. Conditions which are determined by the Veteran’s Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law;

Negligence. For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

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

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

Not Actually Rendered. That are not actually rendered;

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

Occupational. For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit; If you are covered as a Dependent under this Plan and you are self-employed or employed by an Employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all. The claim would be considered if the claim is denied by workers’ compensation;

Other than Attending Physician. Other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider;

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Prohibited by Law. To the extent that payment under this Plan is prohibited by law;

Provider Error. Required as a result of unreasonable Provider error;

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

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

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

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

ARTICLE XV PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

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

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

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

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

Amending and Terminating the Plan

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

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Summary of Material Reduction (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Participant. The 60 day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Participants at least 60 days before the effective date of the Material Modification.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the Family Unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of 31 days from the date written notice is given.

ARTICLE XVI CLAIM PROCEDURES; PAYMENT OF CLAIMS

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

Health Claims

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

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

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

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Participant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

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

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

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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

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

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

Pre-admission certification of a non-Emergency Hospital admission is a “claim” only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Participant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Participant requests extension of the course of treatment beyond that which the Plan has approved.

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

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

When Claims Must Be Filed

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

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

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

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

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

Timing of Claim Decisions

Upon receiving a Clean Claim, the Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre service Non urgent Care Claims.
 - a. If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
 - b. If the Participant or a Provider has not provided all of the information needed to process the claim (a Clean Claim has not been submitted), then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits within a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).
2. Concurrent Claims:
 - a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.
 - b. Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving Urgent Care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Participant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving Urgent Care and decided within the Urgent Care timeframe.
 - c. Request by Participant Involving Non urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre service Non urgent Claim or a Post service Claim).
3. Post service Claims:
 - a. If the Participant has provided a Clean Claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.

- b. If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
4. Extensions – Pre service Non urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

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

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Participant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Participant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided to the Participant, free of charge, upon request; and
9. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Participant will be provided, upon request and free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances.

Requirements for Appeal

The Participant must file an appeal of a post service claim in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

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

HPHG, LLC dba Caprock HealthPlans
 PO Box 54139
 Lubbock, TX 79453-4139
 E-mail: claims@caprockhp.com
 Fax: 806-698-5823
 Phone: 800-747-9446

Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Participant's appeal must be addressed as follows:

1. For Pre-service Claims:
 Participants should refer to their identification card for the name and address of the utilization review administrator. All pre-service claims must be sent to the Third Party Administrator.
2. For Post-service Claims:

HPHG, LLC dba Caprock HealthPlans
 PO Box 54139
 Lubbock, TX 79453-4139
 E-mail: claims@caprockhp.com
 Fax: 806-698-5823
 Phone: 800-747-9446

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

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

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

Timing of Notification of Benefit Determination on Review

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

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. The specific reason or reasons for the denial;
3. Reference to the specific portion(s) of the summary plan description on which the denial is based;
4. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
5. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;
7. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided free of charge upon request;
8. A statement of the Participant's right to bring an action under section 502(a) of ERISA, following an Adverse Benefit Determination on final review; and

9. The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review to be Final

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

Appointment of Authorized Representative

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

Physical Examinations

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

Autopsy

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

Payment of Benefits

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

Assignments

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

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

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

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Non U.S. Providers

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

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

Recovery of Payments

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

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Participant, Provider or other person or entity to enforce the provisions of this section, then that Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

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

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

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

Medicaid Coverage

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

ARTICLE XVII COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

Excess Insurance

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

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

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

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

Allowable Expenses

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

"Claim Determination Period"

"Claim Determination Period" shall mean each Plan Year.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

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

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

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

1. A plan without a coordinating provision will always be the primary plan;
2. If an individual is covered under one plan as a dependent and another plan as an employee, member or subscriber, the plan that covers the person as an employee, member or subscriber (that is, other than as a dependent) is considered primary. The primary plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her Employer’s benefit plan.
3. The plan that covers a person as a dependent (or beneficiary under ERISA) is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See the section on Medicare below for exceptions to this rule.
4. If an individual is covered under a spouse’s plan and also under his or her parent’s plan, the primary plan is the plan of the individual’s spouse. The plan of the individual’s parent(s) is the secondary plan.
5. If one or more plans cover the same person as Dependent Child:
 - The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the Child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years starting after the plan is given notice of the court decree.
 - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
6. Active or inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or dependent of a retired or laid off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph above can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

7. Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four items above applies. (See exception in the Medicare section.)
8. Longer or shorter length of coverage: The plan that covered the person as an employee, member, subscriber or the retiree the longest is the primary.
9. If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.
10. If the above rules do not determine the primary plan, the covered expenses may be shared equally between the plans. This plan will not pay more than it would have paid, had it been primary.

Medicare

If a Participant is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When this Plan is not primary and a Participant is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payment on Medicare Part B services as though Medicare Part B was actually in effect.

Order of Benefit Determination – Medicare

This Plan complies with the Medicare Secondary Payer regulations. Example of these regulations are as follows:

1. This Plan generally pays first under the following circumstances:
 - The Employee continues to be actively employed by the employer and the Employee or Employee’s covered Spouse becomes eligible for and enrolls in Medicare because of age or disability.
 - The Employee continues to be actively employed by the employer, the Employee’s covered spouse becomes eligible for and enrolls in Medicare, and the Employee’s covered Spouse is also covered under a retiree plan through his or her former employer. In this case, the Plan pays first for the Employee and the Employee’s covered Spouse, Medicare pays second, and the retiree plan pays last.
 - For a Participant with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Participant for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
2. Medicare generally pays first under the following circumstances:
 - The Employee is no longer actively employed by an employer; and
 - The Employee or Employee’s Spouse has Medicare coverage due to age, plus the Employee and Employee’s Spouse also has COBRA continuation coverage through the Plan; or
 - The Employee or an Employee’s family member has Medicare coverage based on disability, plus the Employee also has COBRA continuation coverage through the Plan. Medicare normally pays first, however the COBRA continuation coverage may pay first for Participants with ESRD until the end of the 30-month period;
 - The Employee or Employee’s Spouse has retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note: If a person with ESRD was eligible for Medicare based on age or other disability before being diagnosed with ESRD and Medicare was previously paying as the primary plan, then the person may continue to receive Medicare benefits on a primary basis.)

3. Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as the primary payer.

Note: If a Participant is eligible for Medicare as his or her primary plan, all benefits from the Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Participant is enrolled in Medicare.

Right to Receive and Release Necessary Information

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

Facility of Payment

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

Right of Recovery

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

ARTICLE XVIII MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

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

Applicable to All Other Participants Eligible for Medicare Benefits

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

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement and for the first 30 months of Medicare entitlement (with respect to charges Incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XIX
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party;
 - b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. Any policy of insurance from any insurance company or guarantor of a third party;
 - d. 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 Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

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:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
 - c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)' cooperation or adherence to these terms.

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

ARTICLE XX MISCELLANEOUS PROVISIONS

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Use for non-federal government plan & exempt from ERISA This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating Employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable State law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. Additionally, the Plan will comply with any applicable State PPO prompt pay laws.

Clerical Error/Delay

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

Conformity With Applicable Laws

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

Fraud

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

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

Headings

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

No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein,

and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions

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

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice

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

Right of Recovery

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

Statements

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

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

Protection Against Creditors

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

Unclaimed Self-Insured Plan Funds

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

ARTICLE XXI HIPAA PRIVACY

The Plan provides each member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 800-887-2713 or 575-887-1191.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information (“PHI”) or Electronic Protected Health Information (“ePHI”) that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information (“PHI”)** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rule”) set forth by the U.S. Department of Health and Human Services (“HHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Such standards control the dissemination of “protected health information” (“PHI”) of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant’s PHI, and inform him/her about:

1. The Plan’s disclosures and uses of PHI;
2. The Participant’s privacy rights with respect to his/her PHI;
3. The Plan’s duties with respect to his/her PHI;
4. The Participant’s right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan’s privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual’s PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
 - b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. **Treatment, Payment and Health Care Operations:** The Plan has the right to use and disclose a Participant’s PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant’s information; and
3. **Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. **Required by Law:** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. **Public Health and Safety:** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
 - b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - c. Locate and notify persons of recalls of products they may be using; and
 - d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant’s agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor’s parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor’s PHI;
4. **Health Oversight Activities:** The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

5. **Lawsuits and Disputes:** The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. **Law Enforcement:** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. **Decedents:** The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. **Research:** The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. **To Avert a Serious Threat to Health or Safety:** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. **Workers' Compensation:** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. **Military and National Security:** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. **Disclosures to Participants:** The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. **Disclosures to the Secretary of the U.S. Dept of Health and Human Services:** The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Uses and disclosures for marketing;
2. Sale of PHI; and
3. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. **Request Restrictions:** The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

2. **Right to Receive Confidential Communication:** The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. **Right to Receive Notice of Privacy Practices:** The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. **Accounting of Disclosures:** The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. **Access:** The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. **Amendment:** The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. **Fundraising contacts:** The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Privacy Compliance Coordinator Contact Information:

Scot Bendixsen
101 N Halagueno
Carlsbad, NM 88220
Phone: 800-887-2713 or 575-887-1191
Fax: 575-887-5115
E-mail: hr@cityofcarlsbadnm.com

ARTICLE XXII HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Participant who’s PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:
 - a. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
 - b. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a “substitute form”;
 - c. If an urgent notice is required, Plan may contact the Participant by telephone.
 - i. The Breach Notification will have the following content:
 1. Brief description of what happened, including date of breach and date discovered;
 2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
 3. Steps Participant should take to protect from potential harm;

4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ARTICLE XXIII

PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.