

MOFFAT COUNTY BOARD OF COUNTY COMMISSIONERS
1198 W. Victory Way Craig, Colorado 81625
(970) 824-5517

Tony Bohrer
District 1

Melody Villard
District 2

Donald Broom
District 3

Board Meeting Agenda

Minutes will be recorded for these formal meetings

Tuesday, January 28, 2025

8:30 am Pledge of Allegiance

Call to order by the Chairman

Approval of the agenda

Consent Agenda -

Review & Sign the following documents:

Minutes:

- a) January 14 (pgs 3-6)

Resolutions:

- b) 2025-08: Transfer of Intergovernment Funds for the month of December 2024 (pg 7)
- c) 2025-09: Purchase Cards (pg 8)
- d) 2025-10: Accounts Payable - December 2024 (pg 9)
- e) 2025-11: Accounts Payable (pg 10)
- f) 2025-12: Payroll (pg 11)
- g) 2025-13: Transfer of Intergovernment Funds for the month of January 2025 (pg 12)

Contracts & Reports:

- h) Department of Public Health/Colorado Department of Public Health & Environment Substance Abuse/Mental Health Services Assistance Grant (pgs 13-15)
- i) Department of Human Services Laboratory Services agreement (pgs 16-22)
- j) Memorial Regional Health/Moffat County Settlement & Release agreement (pgs 23-26)
- k) NEOGOV Job Posting Site contract (pgs 27-29)
- l) Group Health Benefit Plan – Adoption & Acceptance (pg 30-152)

Please note that the Board may discuss any topic relevant to County business, whether or not the topic has been specifically noted on this agenda

Public Comment/General Discussion:

Staff Reports:

Adjournment

The next scheduled BOCC meeting will be Tuesday, February 11, 2025 - 8:30 am



11:53 AM 1/24/2025

Moffat County's YouTube link to view meeting:

[01-28-25 BOCC Meeting](#)

OR

<https://www.youtube.com/channel/UC0d8avRo294jia2irOdSXzQ>

**** Agenda is Subject to Change until 24 hours before scheduled Hearings****
The Board may alter the times of the meetings throughout the day, or cancel or reschedule noticed meetings



11:53 AM 1/24/2025

Moffat County Board of County Commissioners
1198 W Victory Way Craig, CO 81625

January 14, 2025

In attendance: Tony Bohrer, Chair; Melody Villard, Vice-Chair; Donald Broom, Board Member; Erin Miller, Deputy Clerk & Recorder; Kyler Scott; Candace Miller; Denise Arola; Kathy Kuehl; Bill Kuehl; John Ponikvar; Megan Cook; Martin Minnich; KC Hume; Chip McIntyre; Allison Anthony; Collette Erickson; Chris Nichols; Shannon Bohrer; Josefina Kuberry; Keyara Bohrer

**Call to Order
Pledge of Allegiance**

Commissioner Bohrer called the meeting to order at 8:30 am

Bohrer made a motion to approve the agenda as presented. Villard seconded the motion. Motion carried 3-0.

Consent Agenda –

Review & Sign the following documents: (see attached)

Minutes:

- a) December 31
- b) Board of Public Health: December 31

Resolutions:

- c) 2025-01: Payroll
- d) 2025-02: Official Newspaper
- e) 2025-03: Treasurer Depositories
- f) 2025-04: BCC Meeting Dates/Postings
- g) 2025-05: 2024 A/P
- h) 2025-06: A/P
- i) 2025-07: Payroll

Contracts & Reports:

- j) Treasurer's Reports (3)
- k) Discharge Monitoring Report: Limestone Pit
- l) Department of Human Services/Prather Productions services agreement
- m) Salvage Metal contract w/X-Field Services

Bohrer made a motion to approve the consent agenda items A-M. Broom seconded the motion. Motion carried 3-0.

Please note that the Board may discuss any topic relevant to County business, whether or not the topic has been specifically noted on this agenda

Public Comment/General Discussion:

Bill Kuehl wondered what is the County's definition of the size of a lot? This had been discussed at lot at the last Planning & Zoning Commission meeting and he just wanted clarification on that. The BCC promised they would get him an answer for this. He also asked how the solar farm south of town got approved when it was on a major wildlife migration path? Commissioner Bohrer answered that while the BCC had opposed it, the CPW had approved it., and overruled them.

Keyara Bohrer and Joesfina Kuberry with the High School Key Club came before the BCC and gave an update on the fundraising that their group has been doing. This group works closely with Human Resource Council.

Board of County Commissioners

- Announce Community Volunteer Board seat appointments (see attached)

The appointments are as follows:

Cemetery Board	Duke Duzik Owen Grant
Community Corrections Board	Debbie Belleville Mike Flannery Nele Cashmore
Employee Retirement Board	Bonnie Shirley
Housing Authority Board:	Carol Preece Tom Mathers
Land Use Board:	Miranda Kawcak – Environment Alt Kymm Gresset – Government Alt
Library Board of Trustees	Gloria Devan
LMD:	Wade Gerber Marshelle Gray
MCTA:	Nikki Mowdy
Maybell Community Board:	Casey Herod
Memorial Regional Health Board of Trustees:	Denise Arola
Planning & Zoning Commission:	Ford Richmond (alt to voting seat)

Villard moved to approve the slate of candidates as read. Broom seconded the motion. Motion carried 3-0.

- Commissioner Chair appointment

Bohrer explained that this commission installs a new chairperson every two years, so they each get a turn. Commissioner Broom moved to appoint Commissioner Villard as chair for the Board of County Commissioners. Bohrer seconded the motion. Motion carried 2-0. Villard will begin serving as chair at the January 28th meeting.

8:45 am

Public Hearing:

Planning & Zoning Department – Candace Miller

Review of proposed Zoning Regulation amendments (see attached)

Bohrer read the Public Hearing protocol and declared the Public Hearing open.

The Planning & Zoning Commission has researched and evaluated the current regulations and has proposed minor amendments to the language in portions of “Article II - Interpretations and Definitions” and portions of “Article IV – District Regulations”. A large majority of these articles have not been updated since the mid-80’s and this will help to align the regulations to codes that the County operates under at this time (International Property Maintenance Code).

Miller reviewed the current Zoning Regulations and highlighted the sections that are proposed for amendment.

Public Comment:

(Commissioner Bohrer emphasized that this Public Comment period was strictly to comment on changes to the Planning & Zoning Regulations)

Collette Erickson stated that she rents land on East Victory Way for her horses. She has fears of changes in language regarding temporary worker housing and opposes any “man camps” being allowed in that area.

Allison Anthony feels that anything that involves the International Property Maintenance Code is unconstitutional and should not be allowed.

Kathy Kuehl is also opposed to man camps and had done extensive research on having the temporary workers staying in local hotels/motels.

Megan Cook, a member of the Planning & Zoning Commission, and also a rental property owner, spoke about the reasons behind the updating of the language in the regulations and the need for additional housing for temporary workers.

Bill Kuehl asked the BCC to seriously consider how a man camp would depreciate adjacent property values. He also encouraged that properties get cleaned up across the county.

There was no more public comment. These amendments will be back before the BCC in the form of a resolution at the February 11th meeting.

Craig/Moffat County Airport – Candace Miller

- Present Final Payment approval for Airport project – CR Contracting (see attached)

Miller presented a letter requesting release of final payment to CR Contracting for the apron seal coat and restripe work at the Craig/Moffat County Airport. The Release of Final Payment legal notice was advertised twice in the Craig Press. No notices or claims of outstanding payments have been received.

The final payment amount is \$6283.70.

Broom moved to approve the final settlement to CR Contracting, for the apron seal coat and restripe work at the Craig/Moffat County Airport in the amount of \$6238.70. Villard seconded the motion. Motion carried 3-0.

Fairgrounds – Kyler Scott

- Request to waive standard bid process for replacement of roof under the Grandstands (see attached)
- Approve/award contract for replacement of roof under the Grandstands (see attached)

Due to the urgent nature and uniqueness of this project, Scott requested waiving the standard bidding process for replacement of roof under the Grandstands.

Two bids were received:

Jenison Construction \$127,750

Charchalis Construction \$134,760

Scott recommended going with Jenison Construction. There was discussion about the merits the types of material/warranty that each contractor used in their bids and if either bid included enclosing the open portion to the sub-roof area.

Broom moved to approve waiving the standard bid process for replacement of the sub-roof of the Fairgrounds Grandstands. Villard seconded the motion. Motion carried 3-0.

Villard moved to award the contract for the replacement of the sub-roof of the Fairgrounds Grandstands to the low bid from Jenison Construction in the amount of \$127,750. Broom seconded the motion. Motion carried 3-0.

In discussion, Villard commented that it was good that Jenison could start this project right away. Bohrer said that the BCC understands that it remains to be seen how much damage is actually in place when the contractor tears into it.

Meeting adjourned at 9:58 am

The next scheduled Board of County Commissioners meeting is Tuesday, January 28, 2025

Submitted by:

Erin Miller, Deputy Clerk and Recorder

Approved by: _____

Approved on: _____

Attest by: _____

RESOLUTION 2025-08
 TRANSFER OF INTERGOVERNMENT FUNDS
 FOR THE MONTH OF DECEMBER 2024

WHEREAS, The budget of Moffat County defines moneys that are to be cleared from the various funds.

NOW THEREFORE, BE IT RESOLVED that the Moffat County Treasurer be and he is hereby authorized to clear the following sum of money between the funds as indicated:

<i>From: (Fund)(CREDIT)</i>	<i>Amount</i>	<i>To: (Fund) (DEBIT)</i>	<i>Amount</i>
Sunset Meadows I	467.73	Sunset Meadows I Deposits	467.73
Sunset Meadows II	431.04	Sunset Meadows II Deposits	431.04
Seniors	2,198.69	Sunset Meadows I	2,198.69
TOTALS		TOTALS	
	<u><u>\$ 3,097.46</u></u>		<u><u>\$ 3,097.46</u></u>

Adopted this 28th day of January, A.D. 2025

Chairman

COUNTY OF MOFFAT)
)ss

I, Stacy Morgan, County Clerk and Ex-officio Clerk to the Board of County Commissioners, County of Moffat, State of Colorado do hereby certify that the above and foregoing is a true and complete copy of the resolution as adopted on the date stated.

WITNESS my hand and seal this 28th day of January, A.D. 2025

Clerk & Recorder

RESOLUTION 2025-09
TRANSFER OF PAYMENT OF WARRANTS
FOR THE MONTH OF JANUARY 2025

WHEREAS, The Board of Commissioners of Moffat County, Colorado, have approved the payment of various debts and obligations from the various county funds:

AND WHEREAS, the warrants issued in payment of said debts and obligations have been issued against the Moffat County Warrant Fund:

NOW THEREFORE, BE IT RESOLVED that the Moffat County Treasurer be and he is hereby authorized to transfer money among the various funds as follows:

FROM FUND:	Check Date:	1/28/2025		
General	110	<u>\$16,749.08</u>	CR	0010.7000
Road & Bridge	200	<u>\$3,568.10</u>	CR	0020.7000
Landfill	240	<u>\$41.78</u>	CR	0070.7000
Airport	260		CR	0120.7000
Emergency 911	270		CR	0350.7000
Capital Projects	510		CR	0160.7000
Conservation Trust	211		CR	0060.7000
Library	212	<u>\$563.36</u>	CR	0130.7001
Maybell Sanitation	610		CR	0280.7000
Health & Welfare	720		CR	0080.7000
Senior Citizens	215	<u>\$1,256.76</u>	CR	0170.7000
Internal Service Fund	710		CR	0325.7000
Lease Purchase Fund	410		CR	0175.7000
NCT Telecom	520		CR	0166.7000
Mo Co Tourism Assoc	219	<u>\$764.84</u>	CR	0320.7000
PSC - JAIL	210	<u>\$2,750.64</u>	CR	0072.7000
Human Sevices	220	<u>\$6,165.50</u>	CR	0030.7100
Public Health	250	<u>\$11,256.70</u>	CR	0065.7000
Sunset Meadows I	910	<u>\$4,598.74</u>	CR	0168.7000
Sunset Meadows I Security	910		CR	0167.7000
Sunset Meadows II	920	<u>\$1,403.21</u>	CR	0169.7000
Sunset Meadows II Security	920		CR	0171.7000
Museum	229		CR	0310.7000
ACET	275	<u>\$1,190.10</u>	CR	0040.7000
Shadow Mountain LID	530		CR	0110.7000
MC Local Marketing District	231		CR	0050.7000
To Fund				
Warrant		<u>\$50,308.81</u>	DR	

Adopted this 28th day of January, 2025

Chairman

RESOLUTION 2025-10
TRANSFER OF PAYMENT OF WARRANTS
FOR THE MONTH OF DECEMBER 2024

WHEREAS, The Board of Commissioners of Moffat County, Colorado, have approved the payment of various debts and obligations from the various county funds:

AND WHEREAS, the warrants issued in payment of said debts and obligations have been issued against the Moffat County Warrant Fund:

NOW THEREFORE, BE IT RESOLVED that the Moffat County Treasurer be and he is hereby authorized to transfer money among the various funds as follows:

FROM FUND:	Check Date:	1/28/2025		
General	110	<u>\$18,774.05</u>	CR	0010.7000
Road & Bridge	200	<u>\$108,836.91</u>	CR	0020.7000
Landfill	240	<u>\$35,656.10</u>	CR	0070.7000
Airport	260	<u>\$3,731.08</u>	CR	0120.7000
Emergency 911	270	<u>\$3,235.16</u>	CR	0350.7000
Capital Projects	510	<u>\$8,928.31</u>	CR	0160.7000
Conservation Trust	211		CR	0060.7000
Library	212	<u>\$411.36</u>	CR	0130.7001
Maybell Sanitation	610		CR	0280.7000
Health & Welfare	720		CR	0080.7000
Senior Citizens	215		CR	0170.7000
Internal Service Fund	710		CR	0325.7000
Lease Purchase Fund	410		CR	0175.7000
NCT Telecom	520		CR	0166.7000
Mo Co Tourism Assoc	219		CR	0320.7000
PSC - JAIL	210	<u>\$29,167.13</u>	CR	0072.7000
Human Sevices	220	<u>\$0.26</u>	CR	0030.7100
Public Health	250		CR	0065.7000
Sunset Meadows I	910	<u>\$577.30</u>	CR	0168.7000
Sunset Meadows I Security	910		CR	0167.7000
Sunset Meadows II	920	<u>\$431.37</u>	CR	0169.7000
Sunset Meadows II Security	920		CR	0171.7000
ACET	275		CR	0040.7000
Shadow Mountain LID	530	<u>\$13.00</u>	CR	0110.7000
MC Local Marketing District	231		CR	0050.7000
To Fund				
Warrant		<u>\$209,762.03</u>	DR	

Adopted this 28th day of January, 2025

Chairman

RESOLUTION 2025-11
TRANSFER OF PAYMENT OF WARRANTS
FOR THE MONTH OF JANUARY 2025

WHEREAS, The Board of Commissioners of Moffat County, Colorado, have approved the payment of various debts and obligations from the various county funds:

AND WHEREAS, the warrants issued in payment of said debts and obligations have been issued against the Moffat County Warrant Fund:

NOW THEREFORE, BE IT RESOLVED that the Moffat County Treasurer be and he is hereby authorized to transfer money among the various funds as follows:

FROM FUND:	Check Date:	1/28/2025		
General	110	<u>\$201,324.92</u>	CR	0010.7000
Road & Bridge	200	<u>\$24,038.99</u>	CR	0020.7000
Landfill	240	<u>\$3,449.84</u>	CR	0070.7000
Airport	260	<u>\$882.24</u>	CR	0120.7000
Emergency 911	270	<u>\$134.06</u>	CR	0350.7000
Capital Projects	510		CR	0160.7000
Conservation Trust	211		CR	0060.7000
Library	212	<u>\$5,604.70</u>	CR	0130.7001
Maybell Sanitation	610	<u>\$1,200.00</u>	CR	0280.7000
Health & Welfare	720	<u>\$114,661.19</u>	CR	0080.7000
Senior Citizens	215	<u>\$1,084.07</u>	CR	0170.7000
Internal Service Fund	710		CR	0325.7000
Lease Purchase Fund	410		CR	0175.7000
NCT Telecom	520		CR	0166.7000
Mo Co Tourism Assoc	219	<u>\$6,027.87</u>	CR	0320.7000
PSC - JAIL	210	<u>\$11,912.14</u>	CR	0072.7000
Human Sevices	220	<u>\$8,743.01</u>	CR	0030.7100
Public Health	250	<u>\$7,597.20</u>	CR	0065.7000
Sunset Meadows I	910	<u>\$6,645.26</u>	CR	0168.7000
Sunset Meadows I Security	910	<u>\$150.00</u>	CR	0167.7000
Sunset Meadows II	920	<u>\$11,617.50</u>	CR	0169.7000
Sunset Meadows II Security	920		CR	0171.7000
ACET	275	<u>\$4,500.00</u>	CR	0040.7000
Shadow Mountain LID	530		CR	0110.7000
MC Local Marketing District	231	<u>\$34,676.95</u>	CR	0050.7000
To Fund Warrant		<u>\$444,249.94</u>	DR	

Adopted this 28th day of January, 2024

Chairman

RESOLUTION 2025-12
 PAYMENT OF PAYROLL WARRANTS
 Payroll Ending 1/18/2025

WHEREAS, The Board of Commissioners of Moffat County, Colorado, have approved the payment of various debts and obligations from the various county funds:

AND WHEREAS, the warrants issued in payment of said debts and obligations have been issued against the Moffat County Warrant Fund:

NOW THEREFORE, BE IT RESOLVED that the Moffat County Treasurer be and he is hereby authorized to transfer money among the various funds as follows:

Pay Date 1/31/2025

FROM FUND:

General	0010.7000	\$199,045.28	cr
Road & Bridge	0020.7000	\$134,679.22	cr
Landfill	0070.7000	\$11,819.57	cr
Airport	0120.7000	\$275.35	cr
Library	0130.7001	\$10,871.38	cr
Maybell WWTF	0280.7000	\$0.00	cr
Health & Welfare	0080.7000	\$0.00	cr
Senior Citizens	0170.7000	\$5,147.19	cr
Mo Co Tourism	0320.7000	\$2,431.22	cr
PSC Jail	0072.7000	\$54,416.43	cr
Human Services	0030.7100	\$47,721.32	cr
Public Health	0065.7000	\$11,874.31	cr
SM I	0168.7000	\$3,269.96	cr
SM II	0169.7000	\$3,730.68	cr

TO FUND:

Warrant	0100.1000	\$485,281.91	dr
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Adopted this 28th day of January, A.D. 2025

 Chairman

STATE OF COLORADO)
)ss.
 COUNTY OF MOFFAT)

I, Stacy Morgan, County Clerk and Ex-officio Clerk to the Board of
 County Commissioners, County of Moffat, State of Colorado, do hereby certify

STATE OF COLORADO

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT TASK ORDER

<p>State Agency: State of Colorado for the use & benefit of the Department of Public Health and Environment 4300 Cherry Creek Drive South Denver CO 80246</p>	<p>Contractor: Board of County Commissioners of Moffat County (a political subdivision of the state of Colorado) 1198 West Victory Way, Suite 110 Craig CO 81625 for the use and benefit of Moffat County Public Health</p>						
<p>Main Task Order Contract Number: 23 FAA 00058</p> <p>Task Order Number: 2025*1504</p>	<p>Task Order Performance Beginning Date: The later of the Task Order Effective Date or January 27, 2025</p>						
<p>Task Order Maximum Amount:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Initial Term</td> <td></td> </tr> <tr> <td style="padding-left: 20px;">State Fiscal Year 2025</td> <td style="text-align: right;">\$196,350.00</td> </tr> <tr> <td>Total for All State Fiscal Years</td> <td style="text-align: right;">\$196,350.00</td> </tr> </table>	Initial Term		State Fiscal Year 2025	\$196,350.00	Total for All State Fiscal Years	\$196,350.00	<p>Task Order Expiration Date: September 29, 2025</p> <p>Except as stated in §2.D., the total duration of this Contract, including the exercise of any options to extend, shall not exceed 5 years from its Performance Beginning Date.</p>
Initial Term							
State Fiscal Year 2025	\$196,350.00						
Total for All State Fiscal Years	\$196,350.00						
<p>Pricing/Funding: Price Structure: Cost Reimbursement Contractor Shall Invoice: Monthly Funding Source: Federal \$196,350.00</p>	<p>Miscellaneous: Authority to enter into this Contract exists in: C.R.S. 25-1.5-101 – C.R.S. 25-1.5-113</p> <p>Procurement Method: Exempt Solicitation Number (if any): N/A</p>						
<p>State Representative: Sharon Liu Program Manager PSD/VIP Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246 sharon.liu@state.co.us</p>	<p>Contractor Representative: Sarah Copeland RN-BSN, Director Moffat County Public Health 1198 West Victory Way, Suite 110 Craig CO 81625 sarahcopeland@moffatcounty.net</p>						
<p>Exhibits and Order of Precedence: The following Exhibits and attachments are included with this Contract:</p> <ul style="list-style-type: none"> Exhibit A Additional Provisions Exhibit B Statement of Work Exhibit C Budget Exhibit D Federal Provisions 							
<p>Contract Purpose: To promote substance use prevention throughout a state jurisdiction for individuals and families by building and expanding the capacity of local community prevention providers to implement evidence-based programs.</p>							

In accordance with **§4.B** of the Main Task Order Contract referenced above, Contractor shall complete the following Project:

1. PROJECT DESCRIPTION

Contractor shall complete the Project described in Exhibit B Statement of Work (SOW) that is attached hereto and incorporated herein (the “SOW”). All terminology used in this Task Order and the Statement of Work shall be interpreted in accordance with the Main Task Order Contract unless specifically defined differently in this Task Order. The Statement of Work and Budget are incorporated herein, made a part hereof and attached hereto as Exhibit B - Statement of Work and Exhibit C - Budget.

2. PAYMENT

The State shall pay Contractor the amounts shown in Exhibit C - Budget that is attached hereto and incorporated herein, in accordance with the requirements of the Statement of Work and the Main Task Order Contract. The State shall not make any payment for a State Fiscal Year that exceeds the Task Order Maximum Amount shown above for that State Fiscal Year.

3. PERFORMANCE PERIOD

Contractor shall complete all Work on the Project described in this Task Order by the Task Order Expiration Date stated above. Contractor shall not perform any Work on the Project described in the Statement of Work prior to the Task Order Performance Beginning Date or after the Task Order Expiration Date stated above.

4. TASK ORDER EFFECTIVE DATE:

The Effective Date of this Task Order is upon approval of the State Controller or **January 27, 2025**, whichever is later.

THE PARTIES HERETO HAVE EXECUTED THIS CONTRACT

Each person signing this Contract represents and warrants that he or she is duly authorized to execute this Contract and to bind the Party authorizing his or her signature.

<p>CONTRACTOR Board of County Commissioners of Moffat County (a political subdivision of the state of Colorado) for the use and benefit of Moffat County Public Health</p> <p>_____</p> <p>By: Signature</p> <p>Sarah Copeland</p> <p>_____</p> <p>Name of Person Signing for Contractor</p> <p>ED, RN</p> <p>_____</p> <p>Title of Person Signing for Contractor</p> <p>Date: _____</p>	<p>STATE OF COLORADO Jared S. Polis, Governor Colorado Department of Public Health and Environment Jill Hunsaker Ryan, MPH, Executive Director</p> <p>_____</p> <p>By: Signature</p> <p>_____</p> <p>Name of Executive Director Delegate</p> <p>_____</p> <p>Title of Executive Director Delegate</p> <p>Date: _____</p>
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In accordance with §24-30-202, C.R.S., this Option is not valid until signed and dated below by the State Controller or an authorized delegate.

STATE CONTROLLER
Robert Jaros, CPA, MBA, JD

By: Signature

Name of State Controller Delegate

Title of State Controller Delegate

Effective Date: _____

--Signature Page End--

LABORATORY SERVICES AGREEMENT

AGREEMENT MADE, by and between Moffat County Colorado DHS, Child Support and Foster Care (hereinafter called "CLIENT") and Laboratory Corporation of America Holdings, (hereinafter called "LABORATORY").

WHEREAS, LABORATORY is engaged in the business of providing parentage testing services; and

WHEREAS, CLIENT desires to contract with LABORATORY to provide parentage testing services for CLIENT, and LABORATORY desires to provide the services described herein,

IT IS THEREFORE AGREED AS FOLLOWS:

1. TERM AND TERMINATION

This Agreement shall be in effect from January 1, 2025 to December 31, 2026 for a term of two (2) years. This Agreement may be terminated by either party at any time by giving the other party thirty (30) days prior written notice to the address set forth in Section 10.

2. TESTING SERVICES

LABORATORY agrees to perform such genetic parentage testing services for the CLIENT as are ordered by CLIENT during the term. Such services shall include genetic marker testing as described in Exhibit 1 (attached hereto), as the same may be modified from time to time by LABORATORY, and such additional services as the parties may agree.

3. ADDITIONAL SERVICES

A. SPECIMEN COLLECTION

LABORATORY will provide buccal swab specimen collections at locations and times agreed upon by both parties.

B. SUPPLIES

LABORATORY will provide, at no additional charge, all supplies necessary for the collection, preparation and preservation of all specimens to be submitted to the LABORATORY for testing.

C. CONSULTATION

LABORATORY staff shall be available to consult with CLIENT by telephone during normal LABORATORY working hours to discuss LABORATORY procedures and to explain test results.

4. FEES

LABORATORY agrees to charge, and CLIENT agrees to pay (to the extent responsible for payment), for all laboratory testing and other services provided under this Agreement, in the manner and in the amounts set forth in Exhibit 2 (attached hereto).

5. BILLING

LABORATORY will submit to CLIENT on or about the FIFTEENTH (15th) of each month an itemized statement of services rendered to CLIENT by LABORATORY for the prior month, and CLIENT agrees to remit payment to the LABORATORY upon receipt of said statement. Failure to remit payment within thirty (30) days of receipt of statement may result, among other remedies available to LABORATORY, in the loss or reduction of the CLIENT's special prices on future

services or discontinuation of service. If, as a result of such non-payment, LABORATORY removes special prices, the terms and prices contained in LABORATORY's current Fee Schedule shall be incorporated by reference into this Agreement. LABORATORY may, at its option, reinstate special prices on business referred to LABORATORY after CLIENT brings its balances current. Nothing in the foregoing provision shall serve to waive any rights or remedies available to LABORATORY with respect to its providing of services to CLIENT.

6. ACCREDITATION OF TESTING SITES

Testing performed hereunder shall be performed at LABORATORY's parentage testing facility located in Burlington, North Carolina. The facility is and shall remain a duly licensed clinical laboratory under applicable federal, state and municipal law. Current accreditation's and licenses for the facility are available upon request.

7. PREVENTION OF FRAUD, WASTE AND ABUSE

The terms of this Agreement are intended to be in compliance with all applicable federal, state and local statutes, regulations and ordinances applicable on the date the Agreement takes effect including but not limited to, the Program Fraud Civil Remedies Act of 1986, the Deficit Reduction Act of 2005, the related Federal Civil False Claims Act and State False Claims Acts, and associated whistleblower protections. LABORATORY has written policies and procedures for detecting and preventing fraud, waste, and abuse and expects that test orders, services, supplies or materials provided to LABORATORY are in accordance with the requirements of the applicable federal and state laws.

8. CHANGE IN LAW OR REGULATION

Should either party reasonably conclude that any portion of this Agreement is or may be in violation of such requirements or any other legal requirements or subsequent modifications by federal, state or local authorities, or if any such change or proposed change would materially alter the amount or method of compensating LABORATORY for Services performed for CLIENT or for any other party under this Agreement, or would materially increase the cost of LABORATORY's performance hereunder, the parties agree to negotiate written modifications to this Agreement as may be necessary to establish compliance with such authorities and/or to reflect applicable changes in compensation necessitated by such legal requirements.

9. NON-ASSIGNABILITY

This Agreement shall not be assigned, delegated, or transferred by either party without the written consent of the other party. A merger or corporate reorganization shall not be considered as assignment requiring written consent.

10. NOTICES

Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified or registered mail to LABORATORY at:

Laboratory Corporation of America Holdings
DNA Identification Testing Division
1440 York Court
Burlington, NC 27215
Attn: Contracts Department

with a copy to:

Laboratory Corporation of America Holdings
531 South Spring Street
Burlington, NC 27215
Attn: Law Department

and to CLIENT at:

Moffat County Colorado DHS,
Child Support and Foster Care
1198 W. Victory Way, Suite 204
Craig, CO 81625

11. INDEPENDENT RELATIONSHIP

None of the provisions of this Agreement are intended to create, nor shall be deemed or construed to create, any relationship between the CLIENT and LABORATORY other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees shall be construed to be the agent, employer or representative of the other.

12. FORCE MAJEURE

Neither LABORATORY nor CLIENT shall be liable for any failure or inability to perform their respective obligations under this Agreement due to any cause beyond the reasonable control of the non-performing party, including but not limited to acts of God, regulations or laws of any government or agency (including government or agency mandated restriction or redistribution of supplies and/or personal protective equipment ("PPE")), acts of war or terrorism, acts of civil or military authority, fires, floods, accidents, pandemics (including supply, PPE and labor shortages caused therefrom or as a result thereof), quarantine restrictions, unusually severe weather, explosions, earthquakes, strikes, labor disputes, loss or interruption of electrical power or other public utility, freight embargoes or delays in transportation, or any similar or dissimilar cause beyond its reasonable control (collectively, a "Force Majeure Event"). If a party's non-performance under this section extends for fourteen (14) days or longer, the party affected by such non-performance may terminate this Agreement by providing written notice thereof to the other party

13. WARRANTY

LABORATORY WARRANTS TO CLIENT THAT ALL SERVICES PROVIDED HEREUNDER SHALL BE PERFORMED IN ACCORDANCE WITH ESTABLISHED AND RECOGNIZED IDENTITY TESTING PROCEDURES AND WITH REASONABLE CARE IN ACCORDANCE WITH APPLICABLE FEDERAL, STATE, AND LOCAL LAWS. NO OTHER WARRANTIES ARE MADE BY LABORATORY. IN NO EVENT SHALL EITHER PARTY BE HELD RESPONSIBLE FOR PUNITIVE DAMAGES, OR CONSEQUENTIAL, INCIDENTAL, OR SPECIAL DAMAGES (INCLUDING LOST PROFITS OR REVENUE) INCURRED BY THE OTHER PARTY OR OF ANY THIRD PARTY.

14. BENEFIT

This Agreement is intended to inure only to the benefit of LABORATORY and CLIENT. This Agreement is not intended to create, nor shall be deemed or construed to create, any rights in any third parties.

15. NONDISCRIMINATION
All services provided by LABORATORY hereunder shall be in compliance with all applicable Federal and State laws prohibiting discrimination on the basis of race, color, religion, sex, national origin, handicap or veteran status.
16. HEADINGS
The headings appearing in this Agreement are for convenience and reference only, and are not intended to, and shall not, define or limit the scope of the provisions to which they relate.
17. ENFORCEABILITY/SEVERANCE CLAUSE
The invalidity or unenforceability of any terms or provisions hereto in any jurisdiction shall in no way affect the validity or enforceability of any of the other terms or provisions in that jurisdiction or of the entire Agreement in any other jurisdiction.
18. INTEGRATION
This instrument is intended by the parties as a final expression of their agreement and as a complete statement of the terms thereof, and shall supersede all previous understandings and agreements. The parties shall not be bound by any representation, promise or inducement made by either party or agent of either party that is not set forth in this Agreement. If the terms or conditions contained in any exhibit or attachment to this Agreement or any document incorporated by reference is in conflict with the terms and conditions set forth in the body of the Agreement, the terms and conditions in the Agreement shall control.
19. WAIVER
No course or dealing between CLIENT and LABORATORY or any delay on the part of LABORATORY in exercising any rights it may have under this Agreement shall operate as a waiver of any of the rights of LABORATORY hereunder, and no express waiver shall affect any condition, covenant, rule or regulations other than the one specified in such waiver and that one only for the time and in the manner specifically stated.
20. ACCESS TO BOOKS AND RECORDS
If LABORATORY should be deemed a subcontractor subject to the disclosure requirements of 42 U.S.C. 1395x (v) (1) (I), LABORATORY shall until expiration of four (4) years make available, upon written request to the Secretary of Health and Human Services, or upon request to the Comptroller General, or any of their duly authorized representatives, a copy of this Agreement and the books, documents and records of LABORATORY that are necessary to certify the nature and extent of the costs incurred under this Agreement through a subcontractor with a value or cost of \$10,000.00 or more over a twelve (12) month period. With a third party, such subcontractor shall contain a clause to the effect that, should the third party be deemed a related organization, until the expiration of four (4) years after the furnishing of services pursuant to such subcontract, the third party shall make available upon written request to the Secretary of Health and Human Services, or upon request to the Comptroller General, or any of their duly authorized representatives, a copy of the subcontract, and the books, documents and records of such third party that are necessary to verify the nature and extent of the costs incurred under this Agreement.
21. EFFECTIVE DATE
This Agreement shall not be effective until it is signed by an authorized representative of LABORATORY and an Acceptance Date is assigned by the DNA Identification Testing Division, Contracts Department.

22. MODIFICATION

This Agreement may not be modified except in writing signed by authorized representatives of both parties. All modifications must also be accepted in writing by LABORATORY's DNA Identification Testing Division, Contracts Department Any purchase order or other document issued by the CLIENT with respect to the subject matter of this Agreement shall be subject to and governed by the terms and conditions hereof, and the terms and conditions of this Agreement shall supersede any conflicting, different or additional terms and conditions of such purchase order or other document whether or not they would materially alter this Agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names as their official acts by their respective representatives, each of whom is duly authorized to execute the same.

**Moffat County Colorado DHS,
Child Support and Foster Care**

Signature:

Name:

Title:

Laboratory Corporation of America Holdings

Signature:

Name: Michael F. Minahan

Title: Sr. Vice President and General Manager, Genetics, Women's Health, and Specialty Testing

Division: DNA Identification Testing Division

Date:

EXHIBIT 1
SPECIFICATIONS OF WORK TO BE PERFORMED

SERVICES: LABORATORY will provide genetic parentage testing services for CLIENT. LABORATORY will provide specimen collection services at a mutually agreed upon location(s). All specimens for genetic parentage testing will be handled by standard chain-of-custody procedures. All supplies required for specimen collection, party identification, specimen packaging and transportation will be provided by LABORATORY.

GENETIC MARKER TESTING: LABORATORY has an extensive array of genetic marker tests from which to construct test batteries that will provide at least:

LabCorp's testing provides an average cumulative power of exclusion of greater than 99.99999%. LabCorp's median combined paternity index for non-excluded men is currently greater than one billion to one (1,000,000,000 to 1) (equivalent to a probability of paternity of 99.999999%). If appropriate, LabCorp has the ability to test additional genetic systems. If an individual is excluded, the results will typically reflect inconsistencies in at least four (4) independent test systems

REPORTING OF RESULTS: Upon completion of the test battery ordered, an evaluation of the test results will be performed by a Director. The case will be finalized and a final report issued if (1) the alleged father is excluded from paternity in at least two independent genetic marker systems, or (2) the alleged father is not excluded from paternity and the probability of paternity is equal to or greater than 99.5%. If neither of these conditions is realized, additional testing will be performed until one of these conditions is met. There will be no additional charge for such extended testing. Original reports of test results and evaluation will be mailed to the account, which ordered the testing. Copies of the report will be mailed to those entities designated by the initiating account. In addition, the original Client Authorization/Chain of Custody Form with attached photographs will accompany the original report.

EXPERT WITNESS: LABORATORY will, at the request of CLIENT, provide testimonial and witness services with respect to specimens tested under the Agreement. LABORATORY shall receive a two-week notice by the CLIENT for scheduling an expert to appear.

EXHIBIT 2
FEE SCHEDULE

DNA Collection Services (Staff Collect)	\$38.00 per person
DNA Collection Services (Lab Collect)	\$48.00 per person

SETTLEMENT AND RELEASE AGREEMENT

This Settlement and Release Agreement (Agreement) is entered into by and between The Memorial Hospital dba Memorial Regional Health (MRH) and Moffat County (PLAN). MRH and PLAN may each be referred to below as a Party or collectively as the Parties.

RECITALS

Whereas, MRH and PLAN have identified MRH claims for Hospital, Professional Provider and Ancillary Provider services for dates of service between October 20, 2019 and August 5, 2024 that were not subject to a contract between the parties. The Parties agree an additional payment is required to settle impacted claims that were not paid properly where PLAN is the responsible party for payment (Settlement Claims);

Whereas, PLAN agrees to make payment to MRH to resolve all Settlement Claims in accordance with Section 1: Settlement Payments;

Whereas, by this Agreement, MRH and PLAN seek to resolve their respective rights and claims arising from and related to the Hospital, Professional Provider and Ancillary Provider Claims, without further expense or litigation, and without admitting any liability.

Therefore, in consideration of the mutual promises, conditions and covenants set forth below, MRH AND PLAN each agree as follows:

AGREEMENT

1. Settlement Payment: In consideration for the releases and obligations set forth and agreed to by the parties, the adequacy of which is hereby acknowledged, PLAN agrees to pay MRH an additional payment of \$2,500,000.00 for settlement of claims incurred by PLAN and billed by MRH. The additional payment of \$2,500,000.00 will be paid directly to MRH to be applied to incorrect contractual adjustments taken. Amounts billed and collected from patients shall be limited to deductible and coinsurance assigned on explanations of benefit forms.
2. Prior and/or Future Deductible and Coinsurance Collections: MRH and PLAN acknowledge and agree that any patients' funds balance applied to their deductible and/or coinsurance shall not be refunded by MRH to the patients or PLAN.
3. Patient Current Payments in Process for Services: MRH and PLAN acknowledge and agree that patient balances remaining due to coinsurance or deductibles remain collectible by MRH for healthcare services rendered and that collection procedures shall not cease on these outstanding patient balances.
4. Payments in Excess of Coinsurance or Deductibles: MRH and PLAN acknowledge and agree that MRH will reimburse any patient balances paid to MRH in excess of any patient coinsurance or deductibles, as referenced in Paragraph 1 above. MRH will perform appropriate file audits to identify any overpayments, and reimburse such overpayment amounts to patients within 90-days from the entry of this Agreement.
5. Collection and Credit Reporting: MRH and PLAN acknowledge and agree that MRH will cease collection efforts in connection with any patient balances in connection with the above dates of service, unless a PLAN member has

failed to satisfy the underlying payment terms as outlined in Paragraph 6 of this Agreement. MRH agrees to notify any such credit reporting agency to correct any negative reports for patient balances previously reported, if applicable.

6. Permitted Collection and Credit Reporting: Notwithstanding Paragraphs 3-5 above, MRH reserves the right to initiate collection and/or credit reporting procedures pertaining to any PLAN member who fails to satisfy the underlying payment terms of the PLAN, including, but not limited to, the failure to timely pay co-pays, co-insurance, and/or deductibles to MRH.
7. Mutual Release: With the exception of those covenants, duties and obligations set forth herein, the parties, on behalf of themselves, their heirs, assigns and their estate, release, acquit and forever discharge each other and one another and their agents, affiliates, employees, principals, officers, directors, successors, insurers, attorneys and assigns from any and all claims, demands, causes of action and liability of any kind or nature whatsoever, whether known or unknown, including any other injuries, damages or expenses of whatever kind related to or arising from the claims which have been or could have been asserted in a civil action.
8. Settlement Payment Schedule: Within thirty (30) days from the effective date of the agreement, MRH and PLAN agree to meet and determine a mutually acceptable timeframe for completion of the Settlement Payment set forth in Section 1.
9. Payment in Full for Settlement Claims: The parties understand and agree that the terms of this Agreement will be considered full and final for the resolution of the Settlement Claims. Except for those obligations created by or arising out of this Agreement, MRH and PLAN each release and forever discharge the other, and any and all of their respective predecessors, successors, assigns, parents, subsidiaries, divisions affiliated and related entities, officers, directors, members, employees, shareholders, agents, partners, attorneys, insurance carriers and any and all persons acting by or through each of them or on their behalf or in concert with them (collectively referred to as Related Entities), from any and all claims, demands, liens, agreements, contracts, covenants, actions, suits, causes of action, obligations, debts, expenses, attorneys' fees, damages, judgments, orders and liabilities of whatever kind or nature in law, equity or otherwise, whether now known or unknown, suspected or unsuspected, and whether or not concealed or hidden, that arise from or relate to the Hospital, Professional Provider and Ancillary Provider Claims.
10. Authority: MRH and PLAN each warrant and represent that they have full power and authority to enter into this Agreement and that they have not assigned or transferred to any person not a party to this Agreement any released matter or any part or portion thereof, and that no other releases or settlements are necessary from any other person or entity to release and discharge each other as specified above. Each Party further represents and warrants that the individuals executing this Agreement on behalf of each such Party have all necessary authority to sign this Agreement on behalf of that Party.
11. Construction: Both Parties sought and obtained the advice of legal counsel prior to signing this Agreement and have not relied on any representations made by the other Party or the other Party's counsel before executing this Agreement. Any dispute regarding the interpretation of this Agreement shall not be resolved by any rule of interpretation providing for interpretation against the drafting Party.
12. No Admission of Liability: Neither the execution nor performance of any terms of this Agreement shall constitute or be construed as an admission of any liability or wrongdoing whatsoever by any Party. MRH and PLAN each enter into this Agreement solely for the purposes of avoiding the time consuming and costly prospect of litigation and to buy their respective peace.

13. Voluntary: This Agreement is executed without reliance upon any representation of legal liability and the undersigned have carefully read it, consulted with their attorneys concerning its provisions, understand the contents and sign it voluntarily.
14. Entire Agreement: This Agreement constitutes and contains the entire Agreement and final understanding concerning prosecution and resolution of the Settlement Claims. It is intended by the Parties as a complete and exclusive statement of the terms of their Agreement. It supersedes and replaces all prior negotiations and all agreements proposed or otherwise, whether written or oral, concerning the subject matter hereof. Any representation, promise, or agreement not specifically included in this Agreement shall not be binding upon or enforceable against any Party. This is a fully integrated agreement.
15. Severability of Invalid Provisions. The provisions of this Agreement are declared to be severable. If any provision of this Agreement or the application thereof is held invalid, the invalidity shall not affect other provisions or applications of this Agreement which can be given effect without the invalid provisions or application.
16. Recitals: The Recitals are a material part of this Agreement and are incorporated in their entirety.
17. Governing Law: This Agreement shall be governed by the laws of the State of Colorado to the extent such laws are not deemed preempted by federal laws.
18. Modifications. This Agreement may not be modified in any manner, nor may any rights provided for herein be waived except by an instrument in writing signed by the party to be charged in such modification or waiver.
19. Attorneys' Fees and Costs: The parties shall each bear their respective attorneys' fees and costs incurred, should there have been any incurred.
20. No Waiver of Breach. No waiver of any breach of any term or provision of this Agreement shall be binding unless in writing and signed by the party waiving the breach. No waiver of any breach of any term or provision of this Agreement shall be construed to be, nor shall be, a waiver of any other breach of this Agreement.
21. Counterparts and Duplicates: This Agreement may be executed in counterparts, and each counterpart, when executed, shall have the efficacy of a signed original. Photographic and facsimile copies of such signed counterparts may be used in lieu of the originals for any purpose.
22. Effective Date: This Agreement shall be effective upon signing by both Parties.

THE REMAINDER OF THIS PAGE INTENTIONALLY LEFT BLANK

MRH and Moffat County (PLAN) have executed this Agreement as of the dates set forth below:

THE MEMORIAL HOSPITAL DBA MEMORIAL REGIONAL HEALTH
(TIN: 84-0399209)

By: Jennifer Riley
Jennifer Riley, MHA, FACHE
Chief Executive Officer

Date: January 15, 2025

MOFFAT COUNTY

Name: _____

Title: _____

Date: _____

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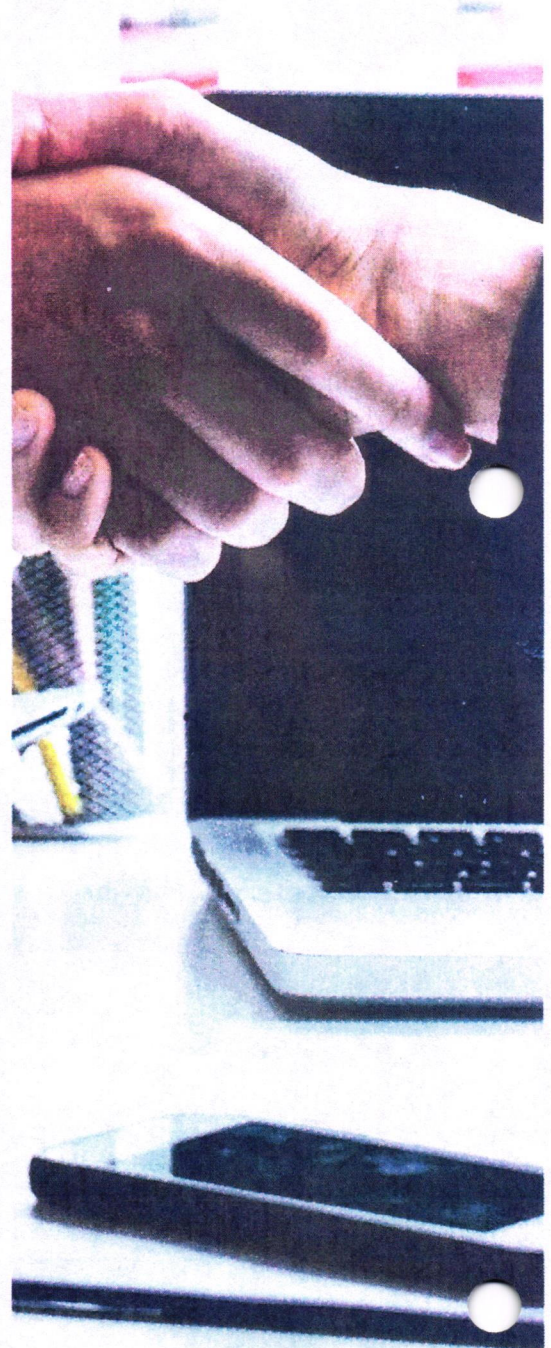
With over 6 million page views a month and more than 14.5 million applications submitted annually, GovernmentJobs.com is the best place to find candidates committed to landing a job in the public sector. Using our job board gives your organization access to 39 million applicant profiles to ensure you find the most qualified candidate for the job.

Host to over 45,000 job postings, GovernmentJobs.com is the #1 public sector job board. Over 1,500 organizations from all 50 states use our job board to advertise their open positions, attracting qualified candidates who are specifically searching for public sector roles.

As you search for candidates, easily track their application process with the seamless integration with NEOGOV's applicant tracking system, Insight. Use Insight to post open positions on GovernmentJobs.com, manage interviews, and even hire through one system. Our solutions work in tandem to help you fill open positions with candidates who are right for your organization.

CREATED FOR YOU *and your applicants*

- ✓ #1 public sector job board
- ✓ 14+ million applications submitted annually
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#1 PUBLIC SECTOR JOB BOARD

GovernmentJobs.com is the largest job board that's focused exclusively on the public sector. Originally developed for the public sector, it was conceived to meet specific compliance standards for government agencies.

- Top rankings on Google for public sector job searches
- Serving the public sector for over 20 years
- Designed for accessibility, meets 508 compliance requirements

ATTRACT MORE QUALIFIED APPLICANTS

Because GovernmentJobs.com is public-sector focused, it's the fastest and most efficient way to find applicants that already have government experience or are looking to start a career in the public sector.

- Over 1.5 million applicants have created profiles on GovernmentJobs.com
- Mobile-friendly application submission process
- Reduce other advertising costs by only targeting public sector job seekers

INTEGRATES WITH INSIGHT

NEOGOV's applicant tracking system integrates directly with GovernmentJobs.com, making it possible for you to post jobs, accept applications, and track candidates all in one place.

- Attract, interview, and hire applicants from one place
- Create job postings in Insight and automatically publish to GovernmentJobs.com
- Enable candidates to self-schedule interviews and view application status
- Includes live support from NEOGOV's customer service agents to reduce applicant calls to your agency

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

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Moffat County** (the "Company" or the "Plan Sponsor") as of **January 1, 2025**. 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 settlor 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.

Moffat County

By: _____

Name: _____

Date: _____

Title: _____

Moffat County Group Health Benefit Plan

Plan Document and Summary Plan Description

Effective: January 01, 2025

THE VALUE OF YOUR GROUP HEALTH PLAN

This is the Plan Document and Summary Plan Description (“Plan Document”), made by **Moffat County** (the “Company” or the “Plan Sponsor”). No oral interpretations can change this Plan. The Plan Sponsor has adopted this Plan Document as the written description of the Plan 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 **Moffat County** and may be reviewed at any time during normal working hours by any Covered Person.

This Group Health Plan provides Covered Persons with important protection against financial hardship that often accompanies Illness or Injury. It has been carefully designed to provide excellent benefits and offers financial incentives if individuals seek the most efficient quality health care services available. The Company provides the Group Health Plan for Employees and Dependents.

Coverage under the Plan will take effect for the Employee and his or her eligible Dependents when the Employee and such Dependents satisfy the Waiting Period and all eligibility requirements of the Plan.

The Company fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including, but not limited to applicable benefit coverage, Deductibles, maximums, Co-payments, exclusions, limitations, definitions, and eligibility.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an Accident, Injury or Illness that occurred, began, or existed while coverage was in force. An expense for a service or supply is Incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination. This document summarizes the Plan rights and benefits for Covered Persons, explaining:

- How to become eligible to participate,
- What benefits are available, and
- How the Plan is administered.

We hope Employees will take the time to review this benefit coverage from **Moffat County** and share with eligible Dependents ways to contribute to making the health care system work cost effectively and efficiently.

Please contact Human Resources Department and/or Claims Administrator with any questions regarding the Plan.

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SCHEDULE OF BENEFITS - HEALTH BENEFIT PLAN

GENERAL LIMITS

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions.

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES

Benefit determination for hospitals, ambulatory health care centers and other facilities for inpatient and outpatient services, except as otherwise specified in this Plan, will be made under the Plan's Claim Review and Audit Program, and covered expenses will be the amount of Allowable Claim Limits subject to the deductibles, co-payments, co-insurance percentage and maximums limits.

Non-Facility Providers will be reimbursed based on what is determined to be a Maximum Allowable Amount for covered services and supplies. Refer to the Plan's Claim Review and Audit Program section of this Plan Document.

SUMMARY OF SERVICES	MEDICAL BENEFITS
Hospital Pre-Admission Review and Other Services Listed Below - Refer To The Section Entitled "Utilization Review Program"	
Non-Compliance Penalty	
Inpatient Admissions	
<i>Acute Care</i>	Pre-certification Required, No Penalty
<i>Extended Care Facility</i>	Pre-certification Required, No Penalty
<i>Rehabilitation Care Facility</i>	Pre-certification Required, No Penalty
<i>Substance Abuse Facility</i>	Pre-certification Required, No Penalty
Partial Hospitalization	Pre-certification Required, No Penalty
Outpatient Surgical Procedures	Pre-certification Required, No Penalty
Bariatric Surgery	Pre-certification Required, No Penalty
Durable Medical Equipment > \$2,000	Pre-certification Required, No Penalty
Genetic Testing	Pre-certification Required, No Penalty
Injectables	Pre-certification Required, No Penalty
Qualifying Clinical Trials	Pre-certification Required, No Penalty
Chemotherapy (Cancer Diagnosis)	Pre-certification Required, No Penalty
Dialysis	Pre-certification Required, No Penalty
Hyperbaric Chamber	Pre-certification Required, No Penalty
Transplants	Pre-certification Required, No Penalty
Occupational Therapy after 25 th Visit	Pre-certification Required, No Penalty
Speech Therapy after 25 th Visit	Pre-certification Required, No Penalty
Physical Therapy after 25 th Visit	Pre-certification Required, No Penalty
Home Health Care	Pre-certification Required, No Penalty
Lifetime Maximum Benefit	Unlimited
Calendar Year Deductible	
Individual	\$750
Family	\$2,250
Separate Prescription Drug Deductible	
Individual	\$50
Family	\$150
Note: The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined. No one person must satisfy more than the Individual Deductible amount.	
Out-of-Pocket Maximum (including Deductible, Co-insurance, Medical Co-payments and Prescription Co-payments)	
Individual	\$6,850
Family	\$13,700
Note: The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined. No one person must satisfy more than the Individual Out-of-Pocket amount.	

SPECIAL COVERAGES

SUMMARY OF SERVICES	MEDICAL BENEFITS
Second Surgical Opinion	100% No Deductible After a \$50 Co-Pay
Expanded Women's Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA)	100% No Deductible
Preventive Care Services as required under the Patient Protection and Affordable Care Act (PPACA) include the following:	100% No Deductible
<i>Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force;</i> <i>Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;</i> <i>Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and</i> <i>Evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.</i> The complete list of recommendations and guidelines can be found at: https://www.healthcare.gov/preventive-care-benefits/	
Acupuncture	100% No Deductible After a \$50 Co-Pay Calendar Year Maximum - 30 Visits combined with Chiropractic Services
Compression Stockings	80% Deductible Applies
Diabetic Counseling	100% No Deductible Calendar Year Maximum - 4 Visits
Dialysis Treatment and Services including End Stage Renal Disease (ESRD)	80% Deductible Applies
Hearing Aids Including Implantable Hearing Devices	80% Deductible Applies Note: \$4,000 maximum every three (3) years.
Lab Card	100% No Deductible
Morbid Obesity Nutritional Counseling - From Age 18	100% No Deductible Calendar Year Maximum - 26 Visits
Nutritional Counseling	100% No Deductible Calendar Year Maximum - 4 Visits
Teladoc	100% No Deductible
Transplants <ul style="list-style-type: none"> • Cigna Lifesource Transplant Contract: 100% No Deductible; otherwise medical benefits apply. • Travel & Lodging Maximum: 100% No Deductible up to \$10,000 maximum with Cigna Lifesource only 	80% Deductible Applies Not Covered
Weight Loss Treatment	Benefit Payable the Same as any other Illness
Wigs (Cranial Prosthesis), Toupees or Hairpieces	80% Deductible Applies Note: Only covered if related to cancer treatment and alopecia areata.

PHYSICIAN AND OFFICE SERVICES

SUMMARY OF SERVICES	MEDICAL BENEFITS
PCP Office Visits - <i>One Co-Pay per Office Visit</i>	100% No Deductible After a \$35 Co-Pay
Specialist Office Visit	100% No Deductible After a \$50 Co-Pay
Surgery	100% No Deductible After a \$35 or \$50 Co-Pay
Diagnostic X-Ray & Lab	100% No Deductible
Advanced Imaging	80% Deductible Applies
Independent Lab, Radiologist & Pathologist	80% Deductible Applies
Allergy Injections, Serum & Sublingual Droops	100% No Deductible
Allergy Testing	100% No Deductible
Chemotherapy	100% No Deductible After a \$35 or \$50 Co-Pay
Physical Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Occupational Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Speech Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Chiropractic Services	
Office Visits	100% No Deductible After a \$50 Co-Pay
Manipulations	80% Deductible Applies
X-Rays	100% No Deductible
	<i>Calendar Year Maximum - 30 Visits combined with Acupuncture</i>
Podiatric Services	
Office Visits	Benefit Payable the Same as any other Illness
Surgery	Benefit Payable the Same as any other Illness
X-Ray & Lab	Benefit Payable the Same as any other Illness
Orthotics	Benefit Payable the Same as any other Illness
Infertility Services	
Initial Diagnostic Testing	100% No Deductible
Infertility Treatment	Benefit Payable the Same as any other Illness <i>Calendar Year Maximum - \$30,000</i>
TMJ Services	
Office Visits	Not Covered
Surgery & Related Services	Not Covered
Mental Health	100% No Deductible After a \$35 Co-Pay
Substance Abuse	100% No Deductible After a \$35 Co-Pay
Other Covered Services	80% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	MEDICAL BENEFITS
Facility	80% Deductible Applies
Ambulatory Surgical Center	90% Deductible Applies
Emergency Room	
Emergency	80% Deductible Applies
Non-Emergency	80% Deductible Applies
Urgent Care	100% No Deductible After a \$50 Co-Pay.
Diagnostic X-Ray & Lab	80% Deductible Applies
Pre-Admission Testing	80% Deductible Applies
Surgeon	80% Deductible Applies
Physical Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Occupational Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Speech Therapy	80% Deductible Applies <i>Note: Medical Necessity Review After 30 Visits</i>
Chemotherapy & Radiation Therapy	80% Deductible Applies
Infertility Services	
Initial Diagnostic Testing	100% No Deductible
Infertility Treatment	Benefit Payable the Same as any other Illness <i>Calendar Year Maximum - \$30,000</i>
Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician	80% Deductible Applies
Mental Health	80% Deductible Applies
Substance Abuse	80% Deductible Applies
Other Covered Services	80% Deductible Applies

INPATIENT HOSPITAL

SUMMARY OF SERVICES	MEDICAL BENEFITS
Facility	80% Deductible Applies
Room, Board & Miscellaneous	80% Deductible Applies
Nursery	80% Deductible Applies <i>Baby & Mother's Charges Will Be Separate</i>
Diagnostic X-Ray & Lab	80% Deductible Applies
Surgeon	80% Deductible Applies
Physician Visits	80% Deductible Applies
Private Duty Nursing	Not Covered
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	80% Deductible Applies
Mental Health	Benefit Payable the Same as any other Illness.
Substance Abuse	Benefit Payable the Same as any other Illness.
Other Covered Services	80% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF SERVICES	MEDICAL BENEFITS
Extended Care Facility / Skilled Nursing Facility	80% Deductible Applies <i>Calendar Year Maximum - 100 Days</i>
Home Health Care - <i>1 visit is up to 4 hours</i>	80% Deductible Applies <i>Calendar Year Maximum - 100 Visits</i>
Hospice Care	80% Deductible Applies
Bereavement Counseling	Not Covered
Respite Care	80% Deductible Applies
Private Duty Nursing	Not Covered
Ambulance	80% Deductible Applies
Durable Medical Equipment	80% Deductible Applies <i>- Limited to the lesser of the purchase price or the total anticipated rental charges.</i>
Prosthetic Appliances	80% Deductible Applies <i>- Includes replacements which are Medically Necessary or required by pathological change or normal growth</i>

PRESCRIPTION DRUG PLAN

PRESCRIPTION DRUG DEDUCTIBLE

Individual	\$50
Family	\$150

RETAIL PRESCRIPTION PLAN

If obtained through the Prescription Drug Plan - 100% after satisfaction of applicable Co-payment: **Per 30 day supply**

Generic	\$15 Co-payment
Preferred Brand	\$40 Co-payment
Non-Preferred Brand	\$70 Co-payment
Brand if no Generic available	\$40 Co-payment
Brand if Physician mandates	\$40 Co-payment
Specialty	\$200 Co-payment

MAIL ORDER PRESCRIPTION PLAN

If obtained through the Mail Order Prescription Drug Plan - 100% after satisfaction of applicable Co-payment: **Per 90 day supply**

Generic	\$30 Co-payment
Preferred Brand	\$80 Co-payment
Non-Preferred Brand	\$140 Co-payment
Brand if no Generic available	\$80 Co-payment
Brand if Physician mandates	\$80 Co-payment
Specialty	Not Applicable

PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS

Applicable Co-payment Applies

COVERAGE INCLUDES

- ◆ Federal Legend Drugs
- ◆ Insulin
- ◆ Diabetic Supplies (lancets, needles, test strips, alcohol swabs)
- ◆ ADHD Drugs
- ◆ Migraine Medication
- ◆ Acne Medication
- ◆ Prenatal Vitamins
- ◆ Narcolepsy Drugs
- ◆ FDA approved forms of Contraceptives for Women
- ◆ Vaccinations/Immunizations
- ◆ Sexual Dysfunction Drugs

COVERAGE EXCLUDES

- ◆ Diagnostic Agents
- ◆ Rogaine & Other Hair Loss Products
- ◆ Growth Hormone Drugs
- ◆ Blood Products (RhoGAM)
- ◆ Anorexiant, Diet Drugs
- ◆ OTC Counterparts
- ◆ Cosmetic Drugs
- ◆ Fertility Drugs
- ◆ Medical Devices
- ◆ Investigational Drugs
- ◆ Anabolic Steroids

Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees, Allowable Claim Limits, Maximum Allowable Amounts And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

PLAN PARTICIPATION

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from you or your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to you will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS

An eligible Employee is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time thirty (30) or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which is combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

REINSTATEMENT FOR COVERAGE

If an Employee is terminated and then re-hired within thirteen (13) weeks, the Employee's coverage will begin immediately after rehire, as long as all other eligibility requirements are also satisfied; or

If an Employee has a break in employment that lasts between four (4) and thirteen (13) weeks, but the Employee's length of employment is less than the length of the break in employment, the Employee will have to satisfy the new hire Waiting Period; or

If an Employee is terminated and then re-hired after thirteen (13) weeks, the Employee's coverage will begin as soon as the Employee satisfies the new hire Waiting Period, as long as all other eligibility requirements are also satisfied.

ELIGIBILITY FOR DEPENDENT COVERAGE

A Dependent is a person who fits one (1) or more of the following categories:

1. Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom you have obtained a legal separation or divorce or who no longer meets the definition of a common-law marriage or civil union spouse. Documentation on a Covered Person's marital status may be required by the Plan Administrator.
2. A Dependent Child until the Child reaches his or her 26th birthday. The term "Child" includes the following Dependents:
 - a. A natural biological Child;
 - b. A stepchild;
 - c. A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age twenty-six (26) as of the date of such placement;
 - d. A Child under your (or your spouse's) Legal Guardianship as ordered by a court;
 - e. A Child who is considered an alternate recipient under a Qualified Medical Child Support Order

A Dependent does not include the following:

- a. A foster Child;
- b. A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
- c. A grandchild;
- d. A Domestic Partner;
- e. A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
- f. Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

1. A Totally Disabled Dependent Child age twenty-six (26) or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
2. A Totally Disabled Dependent Child age twenty-six (26) or over must be unmarried.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- a. The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- b. The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- c. The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If you have a Dependent Child covered under this Plan who is under the age of twenty-six (26) and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would

otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within thirty (30) calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

1. The Dependent must not be able to hold a self-sustaining job due to the disability; and
2. Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable); and
3. The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than twenty-six (26) who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- a. If you apply within thirty (30) days of hire, your coverage will become effective the first day of the month following your date of hire; or
- b. If you are eligible to enroll under the Special Enrollment Provision, your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within thirty-one (31) calendar days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

1. The date your coverage under the Plan begins if you enroll the Dependent at that time; or
2. The date you acquire your Dependent if application is made within thirty-one (31) calendar days of acquiring the Dependent; or
3. The date set forth under the Special Enrollment Provision if your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within thirty-one (31) calendar days following the event; or
4. The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will your Dependent be covered prior to the day your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If you and/or your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- a. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- b. This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- c. The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISIONS

Under the Health Insurance Portability and Accountability Act

This Plan gives each eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to you will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

You and your Dependents may have a special opportunity to enroll for coverage under this Plan if you experience a loss of other health coverage.

In order for you to be eligible for special enrollment rights, you must meet the following conditions:

1. You and/or your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and
2. You and/or your Dependents stated in writing that you declined coverage due to coverage under another group health plan or health insurance policy; and
3. The coverage under the other group health plan or health insurance policy was:
 - a. COBRA continuation coverage and that coverage was exhausted; or
 - b. Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - c. Terminated and no substitute coverage was offered; or
 - d. No longer receiving any monetary contribution toward the premium from the employer.

You or your Dependent must request and apply for coverage under this Plan no later than thirty-one (31) calendar days after the date the other coverage ended.

You and/or your Dependents were covered under a Medicaid plan or state child health plan and coverage for you or your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within sixty (60) days after the date of termination of such coverage.

You or your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within sixty (60) days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within thirty-one (31) calendar days of the marriage, birth, adoption, or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

1. In the case of marriage, on the date of the marriage (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
2. In the case of a Dependent's birth, on the date of such birth; or
3. In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
4. In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
5. In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Covered Person, not including an ex-stepchild or ex-stepchildren who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child(ren) reside with the Covered Person, provided that the Child or Child(ren) are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Covered Person. The Plan Administrator will determine if the QMCSO properly meets the standards described in this section. A properly completed National Medical Support Notice (NMSN) will also be treated as a QMCSO and will have the same effect.

"Alternate Recipient" means any Child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

"Medical Child Support Order" means 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 Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).

2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a Group Health Plan.

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

1. The name of the State child support enforcement agency issuing the notice.
2. The name and mailing address (if any) of the Employee who is a Covered Person under this Plan or is otherwise eligible for enrollment under this Plan.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Covered Person) or the name and address of a State or local official who may be substituted for the mailing address of the Alternate Recipients(s)).
4. The identification of an underlying child support order.

“Qualified Medical Child Support Order” or “QMCSO” means a Medical Child Support Order, issued in accordance with applicable law, and which 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 Covered Person or eligible Dependent is entitled under this Plan.

To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

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

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 Covered Person is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within twenty (20) days, the Child will be enrolled under the Plan’s default option (if any).
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.

A NMSN does not need to be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons and eligible Covered Persons without regard to the provisions herein, 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 the Omnibus Budget Reconciliation Act of 1993 §13822).

When a Medical Child Support Order is received by this Plan, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by such 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.
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of that determination.

In the instance of any National Medical Support Notice received by this Plan, 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,
 - 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.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage that is available and any forms or documents necessary to begin such coverage.

As required by Federal law, the Plan Administrator shall:

1. Establish reasonable procedures to determine whether Medical Child Support Orders or National Medical Support Notices are Qualified Medical Child Support Orders.
2. Administer benefits in accordance with such orders.
3. Such procedures shall
 - a. Be in writing.
 - b. Provide for the prompt notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures upon the receipt by the Plan of the Medical Child Support Order.
 - c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

TERMINATION OF COVERAGE

TERMINATION DATES OF INDIVIDUAL COVERAGE

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

1. The end of the period for which your last contribution is made if you fail to make any required contribution toward the cost of coverage when due; or
2. The date this Plan is canceled; or
3. The date coverage for your benefit class is canceled; or
4. The last day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
5. The end of the stability period in which you became a member of a non-covered class, as determined by the employer except as follows:
 - a. If you are temporarily absent from work due to an approved leave of absence for medical or other reasons, your coverage under this Plan will continue during that leave up to the date the employer ends the continuance, provided the applicable Employee contribution is paid when due.
 - b. If you are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
6. The last day of the month in which your employment ends; or
7. The date you submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

This Plan intends to comply with the provisions of the Family and Medical Leave Act (FMLA). A Leave of Absence runs concurrently with the Family and Medical Leave Act (FMLA).

Refer to the section entitled COBRA for information regarding continued coverage after ceasing to be eligible under the Plan.

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 end of the period for which your last contribution is made if you fail to make any required contribution toward the cost of your Dependent's coverage when due; or
2. The day of the month in which your coverage ends; or
3. The last day of the month in which your Dependent is no longer your legal spouse or does not meet the definition of Common-Law Marriage spouse due to legal separation or divorce, as determined by the law of the state in which you reside; or
4. The last day of the month in which your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
5. If your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
6. The last day of the month in which your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or
7. The date Dependent coverage is no longer offered under this Plan; or
8. The last day of the month in which you tell the Plan to cancel your Dependent's coverage if you are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

9. The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
10. The date you or your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

Refer to the section entitled COBRA for information regarding continued coverage after ceasing to be eligible under the Plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by you or your personal representative.

UTILIZATION REVIEW PROGRAM

This Plan has implemented a program of Utilization Review so that Covered Persons understand the Medical Necessity of a proposed inpatient admission or outpatient surgery recommended by the Covered Person's Physician. The Utilization Review Service is staffed by medical professionals who consult with the Covered Person and his or her Physician to determine the type of care required, the appropriate setting for such care, and quality, yet cost effective care for his or her condition.

The Plan conforms to the procedures, protocols and methodologies of the contracted Utilization Review Service.

ALL BENEFITS PROVIDED BY THIS PLAN FOR CHARGES FOR HOSPITAL CONFINEMENTS ARE SUBJECT TO THE FOLLOWING REQUIREMENTS:

Inpatient Admissions

- Acute Care
- Extended Care
- Rehabilitation Care Facility
- Substance Abuse Facility

Other Required Procedures

- Outpatient Surgical Procedures
- Bariatric Surgery
- Dialysis
- Durable Medical Equipment
- Transplants
- Partial Hospitalization
- Genetic Testing
- Injectables
- Qualifying Clinical Trials
- Hyperbaric Chamber

Therapies & Rehabilitation

- Occupational Therapy
- Speech Therapy
- Physical Therapy
- Chemotherapy
- Home Health Care

PRE-ADMISSION REVIEW

For Non-Emergency Hospital Admissions:

A pre-admission authorization is required at least twenty-four (24) prior to admission to a Hospital as a bed patient. Covered Persons, Physicians or the Hospital must call the Utilization Review Service whenever a Hospital admission is recommended.

The Utilization Review Service will evaluate the Covered Person's planned treatment based upon the diagnosis provided by the Covered Person's Physician and established standards for medical care. After consultation with the

Covered Person's Physician the Utilization Review Service will provide written authorization to the Covered Person, the Hospital, and the Claims Administrator.

The Utilization Review Service's authorization does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

For Emergency Hospital Admissions:

"Emergency Hospital Admission" means an admission for Hospital confinement which, if delayed, would result in disability or death.

In case of an Emergency Hospital Admission, a Covered Person, their Physician, the Hospital or a member of the Covered Person's immediate family must inform the Utilization Review Service of the admission, by telephone, within forty-eight (48) hours after such admission.

For Maternity Hospital Admissions:

Maternity admissions are not considered emergencies. A pre-admission authorization is recommended at least two (2) months prior to the estimated date of delivery. Covered Persons or their Physician must call the Utilization Review Service.

Although the Plan *does* require a Covered Person to notify the Utilization Review Service of their Pregnancy in advance of an admission, the first forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section are automatically authorized. Stays in excess of the forty-eight (48) or ninety-six (96) hours will require authorization through the Utilization Review Service. Under Federal law, Group Health Plans may not restrict benefits for any Hospital length of stay in connection with Childbirth for the mother (if a Covered Person) or newborn Child (if a Covered Person) to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable).

The pre-certification requirement shall be waived for all admissions outside of the United States; however, all other provisions apply.

The Utilization Review Service must be informed of:

- **The name and birth date of the patient**
- **The name and identification number of the Employee**
- **The date of Hospital admission or surgery**
- **The name of the Employer**
- **The admitting diagnosis**
- **The name of the hospital**
- **The name and telephone number of the attending Physician**

CONTINUED STAY REVIEW

Before the Covered Person's scheduled discharge, the Utilization Review Service will call the Hospital and the Covered Person's Physician to confirm the discharge. If additional days of confinement are required because of complications or other medical reasons, the Utilization Review Service will again evaluate the treatment and diagnosis in consultation with the Covered Person's Physician. This process will continue until the Covered Person is discharged from the Hospital.

If Hospital charges are incurred by a Covered Person for a period of Hospital confinement which has NOT been authorized under the Continued Stay Review provisions, the eligible Hospital charges for such confinement will be limited to the charges incurred during the period of Hospital confinement initially authorized.

IF UTILIZATION REVIEW IS NOT USED

If charges are incurred by a Covered Person for the services listed herein have NOT been authorized by the Utilization Review Service as set out under the Utilization Review program provisions, the penalty, as shown on the Schedule of Benefits, will apply.

THE NON-COMPLIANCE PENALTIES WILL NOT ACCUMULATE TOWARD THE REQUIRED DEDUCTIBLE(S) OR TO THE OUT-OF-POCKET MAXIMUMS.

RETROSPECTIVE REVIEW

The Utilization Review Service will review and evaluate the medical records and other pertinent data of an individual whose Hospital stay, or a portion of his stay, was not authorized under the Pre-Admission and/or Continued Stay Review provisions of the Plan.

Requests for such review must be made, in writing, by the attending Physician or Hospital and must define the medical basis for the review.

Benefits will be limited to only those expenses incurred during the period of hospitalization which **would have been** authorized. Benefits are not payable for expenses related to any period of Hospital confinement which is deemed not Medically Necessary.

PRE-SURGICAL REVIEW

Non-Emergency Surgery:

If the Covered Person's Physician recommends non-emergency surgery, meaning any surgery that can be postponed without causing undue risk to the patient, the Covered Person, a member of his or her family or the Covered Person's Physician must contact the Utilization Review Service at least twenty-four (24) hours prior to the proposed surgery for pre-authorization.

Pre-Surgical Review is not required for minor surgical and diagnostic procedures performed in a Physician's office.

ALL OTHER SERVICES

For Other Required Procedures, Therapies & Rehabilitation, authorization is required prior to obtaining or receiving services.

VOLUNTARY SECOND SURGICAL OPINION BENEFIT

If the Covered Person's Physician recommends non-emergency surgery, meaning surgery that can be postponed without causing undue risk, the Plan will pay for any necessary Physician, x-ray or laboratory expense incurred for a second surgical opinion (and a third opinion, if the second opinion does not agree with the first opinion), if:

- **The Physician providing the second or third opinion is not associated with the Physician who first recommended surgery.**
- **The Physician providing the second or third opinion does not perform the surgery.**
- **The second or third opinion is obtained before the recommended surgery.**
- **The Physician providing the second or third opinion is a Board Certified specialist in the appropriate specialty.**
- **The Physician places the second or third opinion in writing.**

An opinion confirming the advisability of surgery may provide greater peace of mind, and a non-confirming opinion may provide an alternative non-surgical method of treatment for the medical condition. If the patient does not use the Benefit, he will be passing up the chance to get additional medical advice.

The Second Surgical Opinion Benefit DOES NOT apply to expenses incurred for or in connection with:

- **Surgical procedures which are not covered under the Plan.**
- **Minor surgical procedures that are routinely performed in a Physician's office, such as incision and drainage of an abscess or excision of benign lesions.**
- **An opinion obtained more than three (3) months after a surgeon first recommended the elective surgical procedure.**

NO SURPRISES ACT

NETWORK AND NON-NETWORK PROVIDER ARRANGEMENT

Except as outlined in “No Surprises Act – Emergency Services and Surprise Bills” below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge 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. The Plan Administrator reserves the right to revoke any previously given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.

To receive benefit consideration, Participants may need to 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.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant’s Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

CONTINUITY OF CARE

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider’s failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan shall notify the Participant in a timely manner that the Participant has rights to elect continued transitional care from the Provider. If the Participant elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan’s notice of termination is provided and ending ninety (90) days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, “continuing care patient” means an individual who:

- 1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,
- 2) is undergoing a course of institutional or Inpatient care from a specific Provider,
- 3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
- 4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
- 5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan’s benefit amount.

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Network claims subject to the No Surprises Act (“NSA”), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan’s Allowable Expense was the Recognized Amount, regardless of the Plan’s actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider’s billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within thirty (30) days of receipt of an initial claim, and if approved will be paid directly to the Provider. Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

CLAIM REVIEW AND AUDIT PROGRAM

Assignment of Benefits

“Assignment of Benefits” means an arrangement whereby a Plan Participant assigns his or her right to seek and receive payment of eligible Plan benefits to a healthcare provider. The Plan Administrator may revoke an Assignment of Benefits at its discretion. If the provider accepts the arrangement, the provider’s right to receive Plan benefits are equal to those of the Plan Participant, and limited by the terms of the Plan. A provider that accepts this arrangement indicates acceptance of the Assignment of Benefits as consideration in full for treatment, supplies and other services rendered, and is bound by the terms of the Plan Document.

All benefits payable by the Plan may be assigned to the provider of services or supplies at the Plan Participant’s option and at the Plan’s discretion unless evidence of previous payment is submitted. Payments made in accordance with an assignment are made in good faith and release the Plan’s obligation to the extent of the payment.

No Plan 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 Plan 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.

Allowable Charge

“Allowable Charge” for a treatment, supply or other services rendered is determined by the Plan, at the Plan’s discretion, by determining the amount established by a negotiated arrangement if one exists, or the lesser of:

- Specified Benefit Amount;
- Gross billed charge made by the provider;
- Usual, Customary and Reasonable payment for the same treatment, service, or supply;
- Prevailing fee charged in an area large enough to obtain a representative cross-section of providers rendering such treatment, supply or services for which the charge is made by Providers of similar skill and experience.

For Covered Charges rendered by a Physician or other professional provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Allowable Charges shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association’s CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS;
- Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed;
- Charges relating to clearly identifiable errors in medical care;
- Charges the Plan cannot identify or understand the item(s) being billed; or,
- Charges identified based upon a medical record review and audit, which determines that a different treatment or different quantity of a drug or supply was provided.

Nothing in this section shall be construed to limit the Plan’s discretion to deem a greater amount payable than the lesser of any of the above-referenced amounts. Furthermore, the Plan is not obligated to consider all factors. In the event that the Plan determines that insufficient information is available to identify the Allowable Charge for a specific service or supply using the listed guidelines above, the Plan reserves the right, in its sole discretion, to determine any Allowable Charge amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Specified Benefit Amount

“Specified Benefit Amount” means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent

that such fees do not exceed the Specified Benefit Amount. The determination that a charge does not exceed the Specified Benefit Amount include, but are not limited to, the following guidelines:

- 1.4 times the Medicare allowed amount for a Hospital facility, facility which is owned and operated by a Hospital, or an Ambulatory Surgery Centers;
- 1.15 times the Medicare allowed amount for pharmacy charges;
- 1.2 times the Medicare allowed amount for Physician and other eligible providers;
- 100% of the Organ Procurement Organization's invoice cost; and,
- 100% of the National Marrow Donor Program's invoice cost.

Usual, Customary and Reasonable

"Usual, Customary and Reasonable" means the common paid amount for the same or comparable service in the geographic area in which the service or supply is furnished. Usual, Customary and Reasonable payment is based upon:

- Amount of resources expended to deliver the treatment;
- Complexity of the treatment rendered;
- Generally accepted billing practices for unbundling or multiple procedures;
- Medicare reimbursement rates for comparable services or supplies;
- Costs of provider for providing the service or supply;
- Charging protocols and billing practices generally accepted by the medical community; and
- Amounts paid after discounts under government and private plans.

Nothing in this section shall be construed to limit the discretion of the Plan. The Plan is not obligated to consider all factors listed above.

Transplants

Medically Necessary charges are incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria:

- Charges do not exceed the Allowable Charge;
- Transplant must be performed to replace an organ or tissue;
- Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her Plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's Plan.

Donor charges include those for:

- Evaluating the organ or tissue;
- Removing the organ or tissue from the donor;
- Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed; and,
- Charges listed above that are not in violation of any federal or state law.

If a transplant is performed pursuant to a negotiated arrangement and the Plan Participant resides 50 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period subject to the maximum benefit as specifically stated in the Schedule of Benefits:

- Transportation expenses to and from the Center of Excellence facility for the following individuals:
 - The Plan Participant; and
 - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child); or
 - One adult to accompany the Plan Participant; and,
 - Living donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

Reasonable lodging and meal expenses incurred for the living donor, Plan Participant, and one or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or one adult companion who is accompanying the Plan Participant, only while the Plan Participant is receiving transplant-related services.

Lodging, for purposes of this Plan, will not include private residences.

PROVIDER APPEALS PROCESS

When a claim is denied, Plan Participants have the option to Appeal the determination, as described in the “**Appeal of Adverse Benefit Determination**” section. The Plan Participant may appoint their Provider as their Authorized Representative for appeal purposes. **Note: this selection of an Authorized Representative is entirely separate from an Assignment of Benefits. Being named an Authorized Representative does not confer an Assignment of Benefits, and receiving an Assignment of Benefits does not make the recipient an Authorized Representative.**

In the interests of fairness and transparency, and in special consideration of the desires of Providers, the Plan will consider an Appeal from a Provider in the same manner that it will consider an Appeal from the Plan Participant, even if the service provider has not attained Authorized Representative status. Furthermore, the Plan will supply the Provider with the results of that Appeal, just as it would to the Plan Participant. In order to avail itself of this service, the Provider in question must comply with the rules and timelines for filing an Appeal in the same way that a Plan Participant would have to, as detailed in the “**Appeal of Adverse Benefit Determination**” section of this document. By availing themselves of this special Appeal service, Providers agree to comply with the conditions of the Appeal set out above, and also agree to seek reimbursement of the claim in question exclusively from the Plan, voluntarily waiving all right to recover, from the Plan or Plan Participant, any amount in excess of the Allowable Charge. Nothing in this paragraph shall be construed to prevent Provider from recovering the Plan Participant’s responsibilities under the terms of this Plan, which are limited to: a) Copayments; b) Deductibles; c) Coinsurance; d) Plan non-compliance penalty fees; e) Services and Supplies that were not covered under the terms of the plan; and f) Charges beyond the limits described in this Plan Document.

For the purposes of the Appeals Process in this section, a provider’s representation that it has received an Assignment of Benefits on a Form UB or Form HCFA (or other claim form of roughly equivalent function) will be sufficient proof for the Plan that benefits are legally assigned to that provider, and the Plan will require no additional documentation in order to proceed.

For more information, please contact the **Plan Administrator**.

DISEASE MANAGEMENT

THE DISEASE MANAGEMENT PROGRAM

Disease Management is a voluntary program that is designed to improve the lives of individuals suffering from chronic, yet treatable, illnesses through education, lifestyle choices, self-care and healthcare intervention.

Chronic illness, such as heart disease, asthma and diabetes, are among the most prevalent, costly and treatable of all health problems. This free benefit program provides the Covered Person with the opportunity to receive the tools and information he or she needs to manage the Covered Person's healthcare and the related healthcare costs. The Disease Management Program is staffed by medical professionals who will consult with the Covered Person and his or her Physician when a chronic medical condition is identified.

The goal of the Disease Management Program is to intervene prior to a catastrophic medical event and to assist the Covered Person in navigating through the healthcare system if a serious medical event does occur. To accomplish this goal, the Disease Management Program provides the highest level of service at the earliest opportunity through education, intensive healthcare management and cost effective care for the Covered Person's specific condition.

The Disease Management Program complies with HIPAA's privacy regulations; the Covered Person's health information will be kept confidential and will only be shared with the people the Covered Person chooses.

THE PROCESS

Care managers identify individuals with chronic medical conditions.

The Covered Person will receive a telephone call from a care manager. If the Covered Person cannot be reached by telephone, the care manager will send information regarding the Disease Management Program to the Covered Person in the mail.

The Covered Person will complete a Health Risk Assessment (HRA) during a telephone interview with the care manager.

Following the Health Risk Assessment (HRA) process, the care manager uses disease-specific protocols and guidelines to educate the Covered Person and manage the Covered Person's case. These guidelines outline the specific needs of the Covered Person's condition and the expected outcomes.

THE KEY FEATURES AND BENEFITS

The Covered Person will receive a packet explaining the Disease Management Program and educational information that is specific to the Covered Person's medical condition.

Care managers will provide intensive planning and case management for medical situations by recommending alternate Treatment Plans, arranging home health care services and equipment rental and coordinating the services of the many providers that may be involved in these designated situations.

A twenty-four (24)-hour a day/seven (7)-days a week, toll-free Nurseline and Health Information Library provide the Covered Person with confidential information on health care issues.

The Disease Management Program does not verify eligibility or benefits. Questions regarding eligibility or benefits must be directed to the Claims Administrator.

CASE MANAGEMENT

Case Management is an added service which is used to assist seriously ill or injured Covered Persons requiring long term care. Case Management nurses can provide intensive planning and management for these special situations by recommending alternate Treatment Plans, arranging Home Health Care services and equipment rental and coordinating the services of the many Providers that may be involved in these designated situations.

Examples of Illnesses or Injuries which may benefit from Case Management services are stroke, premature birth, some forms of cancer, severe burns and head Injury.

The Covered Person must cooperate with the Case Manager and provide all relevant medical information regarding his condition; however, the choice of the course of treatment is the patient's.

Certain circumstances may cause the Plan Administrator to allow charges that would not otherwise be covered if the proposed alternative is shown to be cost effective. Prior to any final determination, the severity of the condition and the prognosis are taken into consideration. The Plan Administrator shall have the right to waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice to the quality of patient care.

MEDICAL EXPENSE BENEFIT

THE DEDUCTIBLE AMOUNT

INDIVIDUAL DEDUCTIBLE

The Individual Deductible amount is shown on the Schedule of Benefits and is the total amount of Covered Expenses that the Covered Person must satisfy in a Calendar Year before the Covered Person is eligible to receive the Medical Expense Benefits.

FAMILY DEDUCTIBLE

When covered family members have satisfied the Family Deductible amount as shown on the Schedule of Benefits in a Calendar Year (no person can contribute more than the Individual Deductible amount), the Plan will not apply Medical Expense Deductibles to the remaining Covered Expenses for all covered family members combined.

CO-INSURANCE FACTOR

After the Deductible is satisfied, the Plan will pay the applicable percentages of eligible medical expenses as shown on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

If, in a Calendar Year, a Covered Person accumulates an Out-of-Pocket Maximum which equals the amount shown on the Schedule of Benefits, the Plan will pay one hundred percent (100%) of any further Covered Expenses incurred during the remainder of that Calendar Year.

FAMILY OUT-OF-POCKET MAXIMUM

When covered family members have satisfied the Family Out-of-Pocket Maximum amount shown on the Schedule of Benefits in a Calendar Year, the Plan will not apply the Co-insurance Factor to and will pay one hundred percent (100%), from that date forward, of any further Covered Expenses for all covered family members for the remainder of that Calendar Year.

COVERED MEDICAL EXPENSES

Reasonable and Customary charges Incurred by, or on behalf of, a Covered Person for the following Medically Necessary items, if performed or prescribed by a Physician for an Injury or Illness, subject to the applicable exclusions and limitations of the Plan, are covered by the Medical Expense Benefit:

Abortion. Abortion when the mother's life is endangered, when Medically Necessary or as a result of rape or incest.

Acupuncture. Charges for acupuncture, including acupuncture provided in lieu of anesthetic.

Advanced Imaging. Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.

Ambulance. Covered Expenses for professional ambulance, including approved available water and rail transportation, 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.

Ambulatory Surgical Center. Services and supplies furnished by an Ambulatory Surgical Center.

Augmentation Communication Devices and related instruction or therapy.

Autism Spectrum Disorder. The charges for treatment of Autism Spectrum Disorder provided to a Dependent Child. Treatment includes all generally recognized services prescribed in relation to Autism Spectrum Disorder by the patient's primary care Physician. "Generally recognized services" may include services such as evaluation and assessment, applied behavior analysis, behavior training and management, Speech Therapy, Occupational Therapy, Physical Therapy and medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Applied Behavioral Analysis. Charges for Applied Behavioral Analysis (ABA) for the treatment of autism spectrum disorder.

Aquatic Therapy. Aquatic therapy by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.

Bariatric Surgery. Bariatric surgery for the treatment of morbid obesity after meeting the following criteria:

- a. Diagnosis of morbid obesity, defined as Body Mass Index (BMI) of greater than or equal to forty (40); or BMI greater than or equal to thirty-five (35) with at least two (2) of the following co-morbid conditions which have not responded to maximum medical management and which are generally expected to be reversed or improved by bariatric treatment: hypertension, dyslipidemia, diabetes mellitus, coronary heart disease, and/or sleep apnea.
 - i. At least a five (5) year history of morbid obesity supported by medical documentation. It is expected that appropriate non-surgical treatment should have been attempted prior to surgical treatment of obesity. The non-surgical treatment of morbid obesity appropriateness criteria includes: Medical record documentation of active participation in a clinically supervised, non-surgical program of weight reduction for at least six (6) months, occurring within the twenty-four (24) months prior to the proposed surgery and preferably unaffiliated with the bariatric surgery program. Note: The initial BMI at the beginning of a weight reduction program will be the "qualifying" BMI used to meet the BMI criteria for the definition of morbid obesity.
 - ii. A program will be considered appropriate if it includes the following components:

1. Nutrition therapy, which may include medical nutrition therapy as a very low calorie diet such as MediFast or 50 OptiFast or a recognized commercial diet-based weight loss program such as Weight Watchers, Jenny Craig, etc.
 2. Behavior modification or behavioral health interventions.
 3. Counseling and instruction on exercise and increased physical activity.
 4. Pharmacologic therapy (as appropriate)
 5. Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health.
- b. In order to be eligible for the surgical treatment of morbid obesity, documentation of the following requirements must be met:
- i. Documentation that growth is completed. (Generally, growth is considered completed by eighteen (18) years of age or with documentation of completed bone growth).
 - ii. Evaluation by a licensed professional counselor, psychologist or psychiatrist, should be completed within the twelve (12) months preceding the request for surgery. This evaluation should document:
 1. The absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations.
 2. Any psychological co-morbidities that are contributing to weight mismanagement or a diagnosed eating disorder.
 3. Patient's willingness to comply with preoperative and postoperative treatment plans.
- c. The following contraindications for surgical treatment of obesity include:
- i. Mental handicaps that render a patient unable to understand the rules of eating and exercise and therefore make them unable to participate effectively in the post-operative treatment program. An example is a patient with malignant hyperplasia (Prader-Willi syndrome), which combines mentally challenged with an uncontrollable desire for food.
 - ii. Portal hypertension, which is an excessive hazard when laparoscopic gastric bypass surgery is performed.
 - iii. Age greater than sixty-five (65) because for these patients the weight loss is less effective, the duration of benefits is shorter and the risks of the procedures are greater.
- d. Coverage excludes cosmetic procedures following surgery, i.e., liposuction, panniculectomy, skin tightening, etc.

Birthing Center. Charges incurred in connection with a Birthing Center (in lieu of Hospital confinement) and Medically Necessary supplies furnished to the mother and necessary supplies furnished to the covered newborn Child, including charges incurred by State certified and/or licensed Midwives at a Birthing Center.

Breast Pumps and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

Breast Reconstruction. Charges for the following expenses related to breast reconstruction in connection with a mastectomy in a manner determined in consultation with the attending Physician and the patient:

- 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.
- c. Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

Cardiac Pulmonary Rehabilitation. Charges when needed as a result of an Illness or Injury.

Cardiac Rehabilitation. Charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered 1) under the supervision of a Physician; 2) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; 3) initiated within twelve (12) weeks after other treatment for the medical condition ends; and 4) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including but not limited to Occupational Therapy or work hardening programs will not be considered Covered Expenses. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

Cataract or Aphakia Surgery. Charges for cataract or Aphakia surgery as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal lenses are not allowable.

Certified Registered Nurse Anesthetist. Anesthesia and its administration when rendered by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or an ambulatory surgical facility.

Chemotherapy or Radiation Therapy. Chemotherapy or radiation therapy by x-ray, radium, radon or radioactive isotopes, or other such treatment or care recommended or prescribed by a Physician.

Chiropractic. Chiropractic care, by any name called, including all professional services for the detection and correction by manual or mechanical means (with or without the application of treatment modalities such as, but not limited to diathermy, ultrasound, heat and cold) to restore proper articulation of joints, alignment of bones or nerve functions. Such care may not be considered a Covered Expense if it is determined to be maintenance palliative. *Benefits are limited to the amount shown on the Schedule of Benefits.*

Cleft Palate and Cleft Lip. Benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

Cochlear Implants. Charges for cochlear implants.

Cosmetic Surgery. Charges for reconstructive or Cosmetic Surgery provided the following conditions are met:

- a. The surgery must be required to correct a condition that results from an Illness or Injury.
- b. The surgery is required to correct the congenital anomaly of a Dependent Child.

Dental. Expenses for the following dental related services and supplies:

- a. Treatment for the repair or alleviation of damage to sound natural teeth due to an accidental Injury, other than from eating or chewing, or treatment of an Injury to the jaw due to an Injury. Treatment must be rendered within twelve (12) months of the Injury.
- b. Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia.
- c. Biopsies of the oral cavity and related anesthesia.
- d. Removal of partial and full bone impacted teeth and related anesthesia.
- e. Expenses billed by a Hospital for Inpatient and Outpatient dental services will be covered if the Covered Person has a serious medical condition that requires hospitalization. Expenses billed by a Hospital for Inpatient and Outpatient dental services will be covered for a Child or for any other Covered Person when the dental services cannot be safely provided due to the Covered Person's physical, mental or medical condition.

Diabetic Education. Services and supplies used in Outpatient diabetes self-management programs are covered under this Plan when they are provided by a Physician.

Diabetic Supplies. Charges for diabetic supplies.

Drugs. Drugs and medications requiring a Physician's written prescription. Drugs and medications purchased through the retail prescription drug plan will be covered as shown on the Schedule of Benefits. Maintenance drugs and medications purchased through the mail order prescription drug plan will be covered as shown on the Schedule of Benefits.

Durable Medical Equipment. Durable Medical Equipment limited to the lesser of the purchase price or the total anticipated rental charges. If the purchase or anticipated rental exceeds \$2,000, pre-approval by the Claims Administrator is required.

Extended Care Facility / Skilled Nursing Facility. Extended Care Facility / Skilled Nursing Facility services (refer to the specific section for coverage details).

Emergency Medical Care and Emergency Accident Care. The initial Outpatient treatment of a medical emergency or an accidental Injury rendered in a Hospital or by a Physician. The term "Medical Emergency" means the sudden and unexpected onset of a medical condition manifesting itself by symptoms severe enough that the absence of medical attention could reasonably result in serious and permanent dysfunction of any bodily organ or part, or other serious and permanent medical consequences. Examples of medical emergencies include, but are not limited to, chest pain, suspected poisoning, severe and persistent abdominal pain, convulsions and emergencies by broadly accepted medical standards.

FDA Approved Medications. FDA approved medications used for conditions other than those for which they received FDA approval, when considered the standard of care and *not* part of a clinical study or in conjunction with any experimental treatment. For the purposes of this Plan, 'Standard of Care' is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, United States Surgeon General, United States Department of Public Health, or the National Institute of Health, and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness. (*Unless otherwise stated under the Approved Clinical Trial section*).

Genetic Counseling.

Genetic Testing. Genetic testing must meet the following requirements:

The test must not be considered Experimental, investigational, or unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

Genetic testing must also meet at least one of the following:

- a. The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
- b. Conventional diagnostic procedures are inconclusive.
- c. The patient has risk factors or a particular family history that indicates a genetic cause.
- d. The patient meets defined criteria that place him or her at high genetic risk for the condition.

Hearing Services. Hearing services include:

1. Exams, tests, services, and supplies to diagnose and treat a medical condition.
2. Purchase or fitting of hearing aids. \$4,000 Maximum every three (3) years.
3. Implantable hearing devices.

Home Health Care. Home health care services (refer to the specific section for coverage details).

Hospice Care. Hospice Care services (refer to the specific section for coverage details).

Hospital Room and Board including bed and board, general nursing care, meals and dietary services provided by the Hospital. All semi-private or ward accommodations are covered.

- a. For private rooms, an allowance will be paid equal to the Hospital's semi-private room charge.
- b. If the Hospital only has private room facilities, private room charges will be considered as semi-private charges.
- c. If a private room is Medically Necessary for isolation purposes, the private room charge will be considered as semi-private.

- d. If intensive care, coronary and intermediate care accommodations are Medically Necessary, the Hospitals actual charges are covered.

Infant Formula. Infant Formula administered through a tube as the sole source of nutrition for the Covered Person.

Infertility. Treatment of infertility or sterility, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer.

Infusion Therapy / Home Infusion Services. Charges for infusion therapy/ home infusion services.

Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

Licensed Psychologist / Social Worker. Licensed Psychologist's and licensed clinical Social Worker's professional medical services for the treatment of psychiatric disorders and Substance Abuse that would be covered if provided by a doctor of medicine (M.D.) and only when the psychologist or social worker is acting within the scope of his license.

Medical and Surgical Supplies. Medical and surgical supplies including bandages, dressings, casts, splints, crutches, cervical collars, head halters, traction apparatus and orthopedic braces.

Miscellaneous Hospital. Miscellaneous Hospital services and supplies including equipment and medications and general nursing care provided to registered Inpatients.

Nutritional Counseling. Charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Physician.

Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes. If they are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

Obstetrical Care. Charges for obstetrical care are paid on the same basis as any other Illness, including pre-natal care, Pregnancy, and miscarriages. Benefits are provided for the Pregnancy of a Dependent Child. Benefits for Pregnancy expenses are paid the same as any other Sickness. *NOTE: Preventive care charges for Pregnancy are covered under the Preventive Care benefit in the Medical Benefits section.*

Benefits are not payable for the newborn unless and until the Employee (the grandparent) becomes the legal guardian for that Child.

Although the Plan *does* require a Covered Person to notify the Utilization Review Service of their Pregnancy in advance of an admission, the first forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section are automatically authorized. Stays in excess of the forty-eight (48) or ninety-six (96) hours will require authorization through the Utilization Review Service. Under Federal law, Group Health Plans may not restrict benefits for any Hospital length of stay in connection with Childbirth for the mother (if a Covered Person) or newborn Child (if a Covered Person) to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable).

Outpatient. Hospital charges for Medically Necessary Outpatient services.

Oxygen. Oxygen and rental of equipment for its administration.

Physical and/or Occupational Therapy. Charges for Physical and/or Occupational Therapy rendered by a licensed physical or occupational therapist for improvement of physical functions impaired due to Injury, Illness or

congenital defect and in accordance with a Physician's orders. The type, frequency and duration of Physical and/or Occupational Therapy must be under reasonable expectations that significant improvement within a reasonable period of time and accepted standards of medical practice is obtained.

Physician's Services. Physician's services for surgery or other necessary medical care, including second surgical opinions, whether rendered in the office, Hospital, home, Extended Care Facility / Skilled Nursing Facility or Hospice Care.

Pre-Admission Testing. Pre-Admission Testing for Medically Necessary diagnostic x-ray and laboratory examinations performed under a Pre-Admission Testing program in the Outpatient department of a Hospital, an ambulatory surgical facility or other facility recognized by the Hospital or Physician provided they are made in contemplation of hospitalization and are made within ten (10) days of a scheduled Hospital confinement. If a confinement is canceled or postponed this benefit will not be payable unless the cancellation or postponement is due to Medical Necessity or the admission is canceled by the Hospital or attending Physician.

Preventive Care Services. Preventive care services. Refer to the Schedule of Benefits for additional information.

This benefit does not include any expenses Incurred in connection with a diagnosed Illness, school physicals or physicals required by a third party.

Benefits mandated through the ACA 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 and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC). Benefits include gender-specific Preventive Care services, regardless of the sex the Participant was assigned at birth, his or her gender identity, or his or her recorded gender.

Prosthetic Devices. Charges for artificial limbs, eyes and other prosthetic devices to replace physical organs and body parts, including replacements which are Medically Necessary or required by pathological change or normal growth. Covered Expenses do not include expenses for the repair or replacement of damaged, lost or stolen devices.

Pulmonary Rehabilitation. Charges for pulmonary rehabilitation.

Renal Dialysis. Renal dialysis treatment, including equipment and supplies when such services are provided in a Hospital, Dialysis Facility or in the home under the supervision of a Hospital or Dialysis Facility.

Renal Dialysis benefits, notwithstanding any Plan provision to the contrary, the Plan shall reimburse treatment for, and related to, or in connection with End Stage Renal Disease (ESRD), chronic kidney disease, or other conditions requiring dialysis services and are subject to the following provisions:

- a. Subject to Pre-Certification, Cost Containment review, negotiation, and/or related administrative services as the designated by the Plan;
- b. The Plan provides for coverage of dialysis treatment at a cost no more than 125% of the Medicare allowable rate, for covered services and/or supplies, after deduction of all amounts payable by Coinsurance and Deductibles. (The Plan reserves the right to allow additional reimbursement levels based on a combination of condition severity, provider availability, geographic and market conditions.);
- c. For maximum coverage, enrollment in Medicare (Parts A and B) upon diagnosis of (ESRD) is recommended to avoid, to the extent possible under federal laws, additional uncovered expenses. If not enrolled, charges over 125% of the Medicare allowable rate, the Covered person may be subject to receiving a bill for the unreimbursed balance, which does not count towards the Deductible and Out-of-Pocket maximums under the Plan; and
- d. All charges must be billed in accordance with generally accepted industry standards.
- e. This provision shall supersede any provision in the Plan that may be in conflict.

Residential Treatment Facility. Services or supplies received at a Residential Treatment Facility.

Respiratory Care. Charges for respiratory care.

Routine Newborn Care. Routine newborn care while Hospital confined, including Hospital nursery care and other Hospital services and supplies and Physicians charges for pediatric care and circumcision.

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 Covered Person 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, as defined under the ACA, provided:

1. The clinical trial is approved by any of the following:
 - a. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services.
 - b. The National Institute of Health.
 - c. The United States Food and Drug Administration.
 - d. The United States Department of Defense.
 - e. The United States Department of Veterans Affairs.
 - f. An institutional review board of an institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services.
2. 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:

1. The cost of an Investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial.
2. 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.
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis.
4. A cost associated with managing an Approved Clinical Trial.
5. The cost of a health care service that is specifically excluded by the Plan.
6. 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.

Sexual Function. Diagnostic services in connection with treatment of male or female impotence.

Sleep Disorders. Services only if Medically Necessary.

Sleep Studies. Charges for sleep studies.

Speech Therapy. Charges for Speech Therapy rendered by a qualified speech therapist in accordance with a Physician's orders when such therapy is administered to restore or rehabilitate speech impairment due to a congenital defect or due to an Injury or due to an Illness that is other than a Non-Organic/Functional disorder (i.e. lisping, stuttering, and stammering), a non-curable developmental disorder (i.e. mentally challenged, down's syndrome, delayed speech or other learning development disorder).

Tobacco Addiction. Preventive / Routine Care as required by applicable law and diagnoses, services, treatment, and supplies related to addiction to or dependency on nicotine.

Voluntary Sterilizations. Voluntary sterilizations, but not the reversal of such procedures.

Weight Loss Treatment.

Wigs (Cranial Protheses), Toupees or Hairpieces. Covered if related to cancer treatment and alopecia areata.

HUMAN ORGAN TRANSPLANT BENEFIT

Coverage includes benefits for Medically Necessary expenses related to human organ, bone marrow/stem cell and tissue transplants at only designated facilities. Expenses incurred by a live organ donor will be covered for each organ transplant procurement.

Expenses incurred for organs obtained through an organ bank or from a cadaver and expenses for storage and transportation that are Reasonable and Customary, are covered under this Plan. If both the recipient and the donor are covered under this Plan, the expenses will be treated separately.

This coverage is subject to the following conditions and limitations:

Transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and cost for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic, autologous and syngeneic bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, small bowel/liver or multivisceral. All other types of organ and tissue transplants will be considered experimental and will be excluded.

Second Opinion

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the designated transplant facility, the Plan will allow them to go to a second designated transplant facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third designated transplant facility accepts the Covered Person for the procedure.

Travel Expenses

Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan.

If the Covered Person or non-covered living donor lives more than fifty (50) miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- a. One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- b. An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

1. Transportation to and from the transplant facility, including:
2. Airfare.
3. Tolls and parking fees.
4. Gas/mileage.

Lodging at or near the transplant facility, including:

- Apartment rental.
- Hotel rental.
- Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Pre-Certification Requirement:

In order to obtain the Network Benefits, Covered Persons must contact the Transplant Coordinator as soon as they are informed that they may be a candidate for one of the covered transplant procedures. Please call the Transplant Coordinator at: Inside Illinois: 1-800-843-3831. Outside Illinois: 1-800-523-0582.

EXTENDED CARE FACILITY / SKILLED NURSING FACILITY

The Plan will provide benefits to the maximum shown on the Schedule of Benefits for charges made by an Extended Care Facility for convalescing from an Illness or Injury. Covered Expenses include:

- Room and Board including charges for services such as general nursing care made in connection with room occupancy. The charge for daily Room and Board is limited to the semi-private room rate,
- Use of special treatment rooms, x-ray and laboratory examination, physical, occupational, or Speech Therapy and other medical services customarily provided by an Extended Care Facility except private duty or special nursing services or Physician's services,
- Drugs, biological solutions, dressings, casts and other Medically Necessary supplies.

Benefits are provided when an individual is confined in an Extended Care Facility if:

- The attending Physician certified that twenty-four (24) hour nursing care is necessary for the recuperation from an Injury or Illness which required the Hospital confinement, and
- He is confined in the Extended Care Facility to receive skilled nursing and physical restorative services for convalescence from the Illness or Injury that caused that Hospital confinement.

HOME HEALTH CARE

The Plan will provide benefits to the maximum shown on the Schedule of Benefits, for charges made by a licensed Home Health Care Agency for the following services and supplies furnished to a Covered Person in his home, or the place of residence used as such person's home for the duration of his Illness or Injury, for care in accordance with a Home Health Care Plan.

The care must be administered in lieu of a Hospital or Extended Care Facility confinement. Expenses for, but not limited to, the following are covered under this benefit:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Part-time or intermittent Home Health Aide services.
- Physical, occupational, respiratory and Speech Therapy.
- Medical supplies, drugs and medicines prescribed by a Physician, and x-ray and laboratory services.
- Medical social services.
- Nutritional counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Renal Dialysis.

The following Home Health Care Expenses are not covered under the Plan:

- Meals, personal comfort items and housekeeping services.
- Services or supplies not prescribed in the Home Health Care Plan.
- Services of a person who ordinarily resides in the Covered Person's home, or who is a member of the Covered Person's or the Covered Person's spouse's family.
- Transportation services.
- Treatment of Psychiatric Disorders of any type, including Substance Abuse.

HOSPICE CARE

The Plan will provide benefits for care received through a home or Inpatient Hospice Care program to which a Terminally Ill Patient was referred by his attending Physician. Expenses for, but not limited to, the following are covered under this benefit:

- Inpatient Hospice, limited to the semi-private room rate.
- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.).
- Physical, occupational, respiratory and Speech Therapy.
- Medical social services.
- Part-time or intermittent Home Health Aide services.
- Medical supplies, drugs, and medicines prescribed by a Physician, and x-ray and laboratory services.
- Physician's services.
- Dietary counseling.
- Respite care to provide temporary relief for three (3) hours, four (4) times per month to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.

The following Hospice Care expenses are not covered under the Plan:

- Transportation services.
- Financial or legal counseling for estate planning or drafting a will.

MEDICAL EXPENSE EXCLUSIONS AND LIMITATIONS

In addition to the General Limitations and Exclusions stated elsewhere in this Plan, the Medical Provisions of this Plan do not cover any loss caused by, incurred for or resulting from:

3D Mammograms. Charges for 3D mammograms unless covered elsewhere in this Plan Document.

Abortions. Charges for abortions unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape.

Alternative or Complementary Medicine. Charges for services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

Assistant Surgeons and Co-Surgeons related to podiatry surgery.

Autopsies. Charges for autopsies not requested by the Plan.

Behavioral Problems. Services or supplies received during an Inpatient stay when the stay is primarily for behavioral problems or social maladjustment or other anti-social actions which are not specifically the result of mental illness.

Bereavement Counseling.

Biofeedback Services.

Blood. Charges for blood and blood donor expenses.

Chelation Therapy. Charges for chelation (metallic ion) therapy.

Cosmetic Surgery. That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. Charges for care that does not restore health, unless specifically mentioned otherwise. Refer to definition of Custodial Care.

Educational or Developmental Training. Charges for testing, training or rehabilitation for educational, developmental or vocational purposes.

Electron Beam Computed Tomography. Charges for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease.

Foot Care. Foot care resulting from:

- a. Weak, strained, unstable, unbalanced or flat feet.
- b. Metatarsalgia or bunions, unless an open cutting operation is performed.
- c. Treatment of corns, calluses or toenails, unless at least part of the nail root is removed or care is necessary for metabolic or peripheral vascular disease.

Gender Transition. Treatment, drugs, medicines, services, and supplies for, or leading to, gender transition surgery.

Genetic Treatment or Engineering. Charges for genetic treatment and engineering, except to the extent required by the Affordable Care Act (ACA).

Growth Hormones.

Home Births. Charges Incurred for home births, including State certified and/or licensed midwives.

Infant Formula. Infant formula not administered through a tube as the sole source of nutrition for the Covered Person.

Intraocular Lenses Other than Conventional Intraocular Cataract Lenses.

Lamaze Classes. Lamaze classes or other childbirth classes.

Learning Disability. Charges for treatment of a learning disability which are not specifically the result of mental illness.

Marriage Counseling or Sexual Therapy. Charges for marriage counseling and/or sexual therapy.

Milieu therapy. Milieu therapy or any confinement in an institution primarily to change or control one's environment.

Miscellaneous Charges. Charges for any of the following items, including their prescription or fitting, except as shown as a Covered Expense:

- a. Optical or visual aids, including contact lenses and eyeglasses; visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
- b. Hair Transplants.
- c. Any examination to determine the need for, or the proper adjustments of any item listed above.
- d. Any procedure or surgical procedure to correct refractive error.

Nocturnal Enuresis Alarm (Bed wetting).

Non-Custom-Molded Shoe Inserts.

Not Approved or Recognized. Charges for care:

1. Not approved or accepted as essential to the treatment of any Illness or Injury by any of the following: the American Medical Association, the United States Surgeon General, the United States Department of Public Health, or the National Institute of Health.
2. Not recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness.

Oral Care. The care and treatment of the teeth, gums or alveolar process, and dentures, appliances or supplies used in such care and treatment, extraction, restoration and replacement of teeth; medical or surgical treatments of dental conditions and services to improve dental clinical outcomes; except as shown as Covered Expenses.

Orthognathic, Prognathic, and Maxillofacial Surgery.

Panniculectomy / Abdominoplasty. Unless determined by the Plan to be Medically Necessary.

Personal Hygiene or Comfort Items. Personal hygiene, comfort or convenience items that do not qualify as Durable Medical Equipment and are generally useful to the Covered Person's household, including but not limited to:

- a. All types of beds, other than Hospital type beds that qualify as a Covered Expense.
- b. Air conditioners, humidifiers (*unless attached to covered equipment*), air cleaners, filtration units and related apparatus.
- c. Whirlpools, saunas, swimming pools and related apparatus.
- d. Medical equipment generally used only by Physicians in their work.
- e. Vans and van lifts, stair lifts and similar other ambulatory apparatus.
- f. Exercise bicycles and other types of physical fitness equipment.

Physical or Occupational Therapy. Physical or Occupational Therapy when it is not a constructive therapeutic activity designed and adapted to promote the improvement of physical function and expenses for supportive (maintenance/palliative) care treatment when maximum therapeutic benefit has been reached.

Private duty nursing.

Radial Keratotomy. Charges for radial keratotomy.

Recreational or Educational Therapy. Recreational or educational therapy or forms of non-medical self-care or self-help training and any diagnostic testing.

School Physicals. Expenses in connection with school physicals required by a third party.

Sex Assignment/Reassignment. Related to a sex change operation.

Sexual Dysfunction Therapy or Surgery. For sexual dysfunctions or inadequacies that do not have psychological or organic basis.

Special Braces and Related Equipment. Special braces, splints, equipment, appliances, battery or anatomically controlled implants unless Medically Necessary.

Standby Surgeon Charges.

Surrogate Parenting and Gestational Carrier Services. Including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

Temporomandibular Joint (TMJ) Dysfunction. Treatment of temporomandibular joint (TMJ) dysfunction with intraoral prosthetic devices, or any other method to alter vertical dimension.

Travel. Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

Vision Care. Vision care unless covered elsewhere in this Plan Document.

Vitamins, Minerals and Supplements. Vitamins, Minerals, and Supplements, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.

Weekend Admissions. Hospital charges that are incurred prior to the first Monday of a confinement that begins on a Friday, Saturday or Sunday, unless:

- a. Such confinement is due to a Medical Emergency.
- b. Surgery is performed within twenty-four (24) hours after such confinement begins.

Wrong Surgeries. Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

Any Other Excluded Items. Any item shown in General Limitations and Exclusions.

GENERAL EXCLUSIONS AND LIMITATIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Covered Person on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Broken Appointments. That are charged solely due to the Covered Person's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Condition of Employment. That are required by any employer as a condition of employment, or rendered through a medical department, clinic or other similar facility provided by an employer or by a union Employee benefit association or similar group of which the person is a member, unless otherwise covered under this Plan.

Confined Persons. That are for services, supplies, and/or treatment of any Covered Person that Incurred while confined and/or arising from confinement in a prison, jail or other penal institution with said confinement exceeding twenty-four (24) consecutive hours.

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

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Covered Person's responsibility in accordance with the terms of the Plan.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental and/or Investigational. That are for charges that are Experimental and/or Investigational.

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

Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment. Charges except for services that are Incurred in the event of an Emergency.

Government. That the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities.

- a. That are furnished to the Covered Person in any veteran's 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.

- b. That 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.

Health Examinations. That are required for the use of a third party, unless otherwise covered under this Plan.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions 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. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

No Legal Obligation. That are for services provided to a Covered Person for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Covered Person or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. That are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Caused By Illness or Resulting From Bodily Injury. That are not caused by Illness or not resulting from bodily Injury, except as shown as a Covered Expense.

Not Cost Effective. That are not cost effective compared to established alternatives, or which are provided for the convenience or personal use of the Covered Person.

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Occupational/ Work or Employment Related. That are 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. Participants that are self-employed or employed by an employer that does not provide health benefits should ensure that they have other medical benefits to provide for medical care in the event they are hurt on the job. In most cases workers' compensation insurance will cover the costs, but if the Participant does not have such coverage he or she may end up with no coverage at all.

Other than Attending Physician. That are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or Illness and performed by an appropriate Provider.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Claims Administrator; including interest or financing charges.

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. That are to the extent that payment under this Plan is prohibited by law.

Provider Error. That are required as a result of unreasonable Provider error.

Standards of Medical or Dental Practice. That do not meet accepted standards of medical or dental practice including, but not limited to, services which are Experimental or Investigational in nature.

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

Telephone Conversations. That are for telephone conversations or consultations, unless otherwise shown as a Covered Expense.

Timely Filing. That are submitted more than twelve (12) months after the date Incurred, except that failure to submit within the stated time shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to submit such claim in a timely manner and that the claim was submitted as soon as was reasonably possible.

Travel. That are Incurred outside the United States if:

- a. The Covered Person traveled to such location to obtain medical services, drugs or supplies.
- b. Such services, drugs or supplies are unavailable or illegal in the United States.

Unbundling. That are made separately for services and/or procedures, supplies and materials when they are considered to be included within the charge for a total service payable, or if the charge is payable to another provider.

Unreasonable. That are not "Reasonable;" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent payments of benefits which exceed expenses. It applies when the Employee or any eligible Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one (1) coverage exists, one (1) plan normally pays its benefits in full and the other plan(s) pay a reduced benefit. This Plan will always pay either its benefits in full or, when this Plan has secondary responsibility, a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If requested, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment. All benefits contained in this Plan are subject to this provision.

Benefits Subject to This Provision

This following shall apply to the entirety of the Plan and all benefits described therein. There is no Coordination of Benefits within this Plan. Coordination is applicable only with other plans.

Excess Insurance

If at the time of Injury, sickness, Illness or disability there is available, or potentially available any other source of 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 (PIP), no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

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.

This Plan does not permit Covered Persons to opt out of no-fault auto insurance as the primary plan. If the Covered Person should opt out, be aware that this Plan will reimburse the Covered Person as the secondary plan only under the assumption that the Covered Person has received primary reimbursement from the Covered Person's auto insurance to the maximum limit available. Therefore, in order to be eligible for secondary reimbursement for automobile-accident related medical costs, a Covered Person: (1) must have maximum PIP coverage, and (2) must have exceeded that coverage limit.

Allowable Expenses

"Allowable Expenses" shall mean the Reasonable and Customary charge for any Medically Necessary, 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, 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 instead of 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 Calendar 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 each one's plan formula minus the amount the primary plan paid. 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. The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, shall be determined before the benefits of a plan which covers such person as a dependent;
3. The Plan that covers the person (and his or her dependents) as an active Employee, pays before the plan that covers the person as a retired or laid-off Employee or COBRA continuant.
4. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - a. When the parents were never married, are separated or are divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - b. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

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

5. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
6. To the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provisions or any provision of similar purpose of any Other Plan. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments section, 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 section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one (1) 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 Covered Person or his or her Dependents. Please see the Recovery of Payments section.

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, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.
3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.
4. If there is more than one (1) party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one 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 Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable

costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Covered Person(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party.
 - b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
 - c. Any policy of insurance from any insurance company or guarantor of a third party.
 - d. Workers' compensation or other liability insurance company.

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

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
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, express 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 Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
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 Covered Person(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, Illness or disability.

COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:
 - a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
 - b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
 - c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
 - d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

RELEASE OF LIABILITY

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

EXCESS INSURANCE

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

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

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, including any similar coverage under a different name in a particular state.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

SEPARATION OF FUNDS

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

WRONGFUL DEATH

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

OBLIGATIONS

1. It is the Covered Person's/ Covered Persons' 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, Illness, 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.
 - f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
 - g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
 - h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
 - i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
 - j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
 - k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.
 - l. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
 - m. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/ Covered Persons' cooperation or adherence to these terms.

OFFSET

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

MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

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

MEDICARE

Medicare means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 or as later amended.

Full Medicare coverage means coverage for all the benefits provided under Medicare (including Medicare Part A and Part B) established by Medicare.

Medical charges as used in this provision with respect to any services, treatments or supplies, means the charges actually made for such services, treatments or supplies to the extent usual and customary.

ACTIVE EMPLOYEES AGE SIXTY-FIVE (65) OR OVER

For active Employees age sixty-five (65) or over who continue to participate in this Plan, this Plan will provide its full regular benefits first and Medicare coverage would provide supplemental benefits for those expenses not paid by this Plan.

If the active Employee's Spouse is also enrolled in this Plan, this provision would apply to the Spouse during the period of time the Spouse is sixty-five (65) or over, regardless of the age of the Employee.

This provision does not apply to individuals entitled to Medicare because of end stage renal disease (ESRD) and/or disability.

CERTAIN DISABLED INDIVIDUALS

(Employers with one hundred (100) or more Employees)

This Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for Disabled individuals who are "currently working" (as defined by Medicare) covered Employees or covered Dependents of such Employees.

Effective August 10, 1993, Medicare will be the primary payor and this Plan will be the secondary payor for the payment of benefits for Disabled individuals who are not "currently working" (as defined by Medicare) covered Employees or covered Dependents of such Employees. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision does not apply to "currently working" Disabled individuals entitled to Medicare because of end stage renal disease (ESRD) during the period of time which Medicare is the primary payor and the Plan is the secondary payor as prescribed by law.

CERTAIN DISABLED INDIVIDUALS

(Employers with less than one hundred (100) Employees)

For covered individuals who are totally Disabled who are eligible for Medicare benefits, both Medicare Part A (Hospital portion) and Medicare Part B (doctor's portion) will be considered the primary payor in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

APPLICABLE TO ALL OTHER COVERED PERSONS ELIGIBLE FOR MEDICARE

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 section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

For a Covered Person who is eligible for Medicare benefits, both Medicare Part A (Hospital portion) and Medicare Part B (doctor's portion) will be considered in computing benefits under this Plan.

INDIVIDUALS WITH END STAGE RENAL DISEASE

For a Covered Person with end stage renal disease (ESRD) who is eligible for Medicare benefits, this Plan will be the primary payor and Medicare will be the secondary payor for the payment of benefits for the period of time specified by law, after which time Medicare will become the primary payor and this Plan will be the secondary payor. Both Medicare Part A (Hospital portion) and Medicare Part B (doctor's portion) will be considered in computing benefits under this Plan. The benefits of Medicare and this Plan are fully coordinated to provide benefits totaling not more than the actual expenses incurred.

This provision intends to comply with the TEFRA Act of 1982, the DEFRA Act of 1985, the COBRA Act of 1985 and the OMBRA Act of 1986 and all similar Federal acts.

CONTINUATION OF COVERAGE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. Under the Plan, certain Covered Persons and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Covered Person or their covered Dependents to make timely payment of contributions or premiums. For additional information, Covered Persons should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Covered Persons may have other options available when group health coverage is lost. For example, the Covered Person may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Covered Person may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Covered Persons can learn more about many of these options at www.healthcare.gov. Additionally, the Covered Person may qualify for a thirty (30)-day special enrollment period for another group health plan for which the Covered Person is eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your Spouse and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage) before the group health coverage is continued and monthly payments must be made in order to continue the coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one (1) of the following Qualifying Events happens:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.

If you are the Spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happens:

- Your Spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment end for any reason other than gross misconduct.
- Your Spouse becomes entitled to Medicare benefits (Part A, Part B or both).
- You become divorced or Legally Separated from your Spouse.

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

- The parent-Employee dies.
- The parent-Employee's hours of employment are reduced.
- The parent-Employee's employment ends for any reason other than gross misconduct.
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B or both).
- The parents become divorced or Legally Separated.
- The Child stops being eligible for coverage under the Plan as a "Dependent Child".

Sometimes, filing a proceeding in bankruptcy under title eleven (11) of the United States Code can be a Qualifying Event, but only if the Plan offers retiree coverage. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse and Dependent Children will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer must notify the Plan Administrator within thirty (30) days of any of these events.

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

In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her Spouse.
2. **Notice of Child's Loss of Dependent Status:** 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 a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of eighteen (18) (or twenty-nine (29) months.
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of eighteen (18) months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first sixty (60) days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator. Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Notification must be received by the COBRA Administrator, who is:

Moffat County
1198 West Victory Way, Suite 111
Craig, CO 81625
Phone: 1-970-824-9108

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, notice must be furnished within sixty (60) days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than sixty (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 Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.
4. The date on which the Qualified Beneficiary 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 provided within the first eighteen (18) months of COBRA Continuation Coverage.

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

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary 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 eighteen (18) month COBRA coverage period.

Who Can Provide the Notice

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

Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
 - a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation.
 - b. 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.
 - c. 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).
 - d. 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.
 - e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, 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.
 - f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary 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.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.
9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than thirty-six (36) months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within thirty (30) days after the

deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the 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 Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

How Is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, your divorce or legal separation, a Dependent Child's losing eligibility as a Dependent or loss of coverage due to Medicare Entitlement (under Part A, Part B or both), COBRA continuation lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension Of The Eighteen (18) Month Period

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be Disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started some time before the sixtieth (60th) day of COBRA continuation coverage and last at least until the end of the eighteen (18) month period of COBRA continuation coverage. A copy of the Notice of Award from the Social Security Administration must be submitted to the Plan Administrator and the COBRA Administrator within sixty (60) days of receipt of Notice of Award and before the end of the eighteen (18) month period of COBRA continuation coverage.

Second Qualifying Event Extension Of Eighteen (18) Month Period

If your COBRA covered family members experience another COBRA Qualifying Event within the first eighteen (18) months of COBRA continuation coverage, the Spouse and Dependent children in your family may be eligible to receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the secondary event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving COBRA continuation coverage if the Employee or former Employee dies, or is divorced or Legally Separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child. In all cases, the eighteen (18) month extension is available only if the second Qualifying Event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

The following example shows how the second Qualifying Event rule works. Former Employee A elects eighteen (18) months of COBRA continuation coverage for the entire family. After the first six (6) months of COBRA

continuation coverage, former Employee A becomes entitled to Medicare (Part A, Part B or both). If former Employee A were still actively employed, entitlement to Medicare **would not** result in a loss of coverage under the Employer's Group Health Plan. The additional eighteen (18) month extension is not available for the former Employee's Spouse and Dependents because if Medicare entitlement had occurred during active employment there would have been no loss of Employer Group Health Plan coverage.

In all of these cases, you must notify the Plan Administrator within sixty (60) days of the second Qualifying Event.

Early Termination Of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the maximum period if:

- The Qualified Beneficiary fails to make the required contributions when due.
- The Qualified Beneficiary becomes covered under another Group Health Plan after the date of the COBRA election.
- The Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both) after electing COBRA continuation coverage.
- The Employer ceases to provide any Group Health Plan for its Employees.

How Can You Elect COBRA Continuation Coverage?

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the Employee's Spouse may elect COBRA continuation coverage even if the Employee does not. COBRA continuation coverage may be elected for only one, several or for all Dependent Children who are Qualified Beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any Dependent Children. The Employee or the Employee's Spouse can elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

How Much Does COBRA Continuation Coverage COST?

Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred fifty percent (150%) of the cost to the Group Health Plan (including both Employer and Employee contributions) for coverage of a similarly situated Covered Person or Beneficiary who is not receiving COBRA continuation coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, Co-insurance, and Co-payments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or

the Children's Health Insurance Program (CHIP). You can access the Marketplace for your State at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have sixty (60) days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After sixty (60) days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "annual enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next annual enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace annual enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another Qualifying Event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next annual enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace annual enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another Group Health Plan?

You may be eligible to enroll in coverage under another Group Health Plan (like a spouse's plan), if you request enrollment within thirty (30) days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another Group Health Plan for which you're eligible, you'll have another opportunity to enroll in the other Group Health Plan within thirty (30) days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to one hundred two percent (102%) of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance Payments:** If you lost your job and got a severance package from your former Employer, your former Employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay Co-payments, deductibles, Co-insurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher Co-payments.

When and How Must Payment for COBRA Continuation Coverage be Made?

First Payment For COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator or Plan Administrator to confirm the correct amount of your first payment.

Periodic Payments For COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each Qualified Beneficiary is shown on the Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace Periods For Periodic Payments

Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator or COBRA Administrator.

If You Have Questions

Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Group Health Plans, contact the nearest Regional or District Office of the United States Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at <https://www.dol.gov/agencies/ebsa>.

Keep Your Plan Informed

In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status, Dependent status or address change. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Moffat County
221 W. Victory Way, Suite 100
Craig, CO 81625
1-970-824-9108

CONTINUATION DURING FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE

The Plan shall at all times comply with FMLA (if applicable). It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

Family and Medical Leave Act of 1993 (FMLA)

This applies to employers with fifty (50) or more Employees within seventy-five (75) miles for at least twenty (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 the Company for at least twelve (12) months, has performed at least one thousand two hundred fifty (1,250) hours of service during the previous twelve (12) month period, and has worked at a location where at least fifty (50) Employees are employed by the Employer within seventy-five (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 eighteen (18) years of age, or eighteen (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 or covered veteran)

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

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 twelve (12) weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to Pregnancy, prenatal medical care or Childbirth;
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.

Spouses employed by the same employer are jointly entitled to a combined total of twelve (12) workweeks of FMLA leave for the birth and care of the newborn child, for placement of a child for adoption or foster care, and to care for a parent who has a serious health condition. Leave for birth and care or placement for adoption or foster care must conclude within twelve (12) months of the birth or placement.

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 twelve (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 twenty-six (26) weeks of leave to care for a covered service member during a single twelve (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 (5)-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 twelve (12) months, have one thousand two hundred fifty (1,250) hours of service in the previous twelve (12) months*, and if at least fifty (50) Employees are employed by the Employer within seventy-five (75) miles.

***Special hours of service eligibility requirements apply to airline flight crew Employees.**

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 three 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 thirty (30) days' advance notice of the need to take FMLA Leave when the need is foreseeable. When thirty (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.
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 United States 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

<https://www.dol.gov/whd/>

United States Department of Labor Wage and Hour Division

WHD Publication 1420 · Revised February 2013

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain Employees who are involved in the uniformed services (defined below). In

addition to the rights that Employees have under COBRA, Employees are entitled under USERRA to continue the coverage that they (and their covered Dependents, if any) had under the Medical and/or Dental Plan.

Employees Have Rights Under Both COBRA and USERRA

Employees’ rights under COBRA and USERRA are similar but not identical. Any election that an Employee makes pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give an Employee (or their covered Spouse or Dependent Children) different rights or protections, the law that provides the greater benefit will apply.

Definitions

“*Uniformed Services*” means the Armed Forces, The Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

“*Service in the uniformed services*” or “*service*” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

Duration of USERRA Coverage

General Rule: Twenty-four (24) month maximum. When a Covered Employee takes a leave for service in the uniformed services, USERRA coverage for the Employee (and covered Dependents for whom coverage is elected) begins the day after the Employee (and covered Dependents) lose coverage under the Plan, and it can continue for up to twenty-four (24) months. However, USERRA coverage will end earlier if one of the following events takes place:

1. A premium payment is not made within the required time;
2. The Employee fails to return to work within the time required under USERRA (see below) following the completion of the Employee’s service in the uniformed services; or
3. The Employee loses his or her rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Returning to Work: An Employee’s right to continue coverage under USERRA will end if the Employee does not notify the Company of their intent to return to work within the time required under USERRA following the completion of their service in the uniformed services by either reporting to work (if the Employee’s uniformed services was for less than thirty-one (31) days) or applying for reemployment (if the Employee’s uniformed services was for more than thirty (30) days). The time for returning to work depends on the period of uniformed services, as follows:

Period of Service	Return-to Work Requirement
Less than thirty-one (31) days	The beginning of the first regularly scheduled work period on the day following the completion of the Employee’s service, after allowing for safe travel home and an eight (8)-hour rest period, or if that is unreasonable or impossible through no fault of the Employee, as soon as is possible.
More than thirty (30) days but less than one hundred eighty-one (181) days	Within fourteen (14) days after completion of the Employee’s service or, if that is unreasonable or impossible through no fault of the Employee, the first day on which it is possible to do so.

More than one hundred eighty (180) days	Within ninety (90) days after completion of the Employee's service.
Any period if for purposes of an examination for fitness to perform uniformed service.	The beginning of the first regularly scheduled work period on the day following the completion of the Employee's service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of the Employee, as soon as is possible.
Any period if the Employee was Hospitalized for or is convalescing from an Injury or Illness incurred or aggravated as a result of the Employee's service.	Same as above (depending on length of service period) except that time periods begin when the Employee has recovered from their injuries or Illness rather than upon completion of the Employee's service. Maximum period for recovering is limited to two (2) years, but the two (2)-year period may be extended if circumstances beyond the Employee's control make it impossible or unreasonable for the Employee to report to work within the above time periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (it may continue for a longer period and is subject to early termination, as described in the COBRA section. In contrast, USERRA coverage can continue for up to twenty-four (24) months, as described above.

Premium Payments for USERRA Continuation Coverage

If the Employee elects to continue their health coverage (or their Spouse's or Dependent Children's coverage) pursuant to USERRA, the Employee will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if the Employee's uniformed service period is less than thirty-one (31) days, the Employee is not required to pay more than the amount that they pay as an active Employee for that coverage.

Questions

If Employees have any questions regarding this information or their rights to coverage, they should contact their Human Resources Department.

Reinstatement of Coverage

When coverage under this Plan is reinstated, all provisions and limitations of this Plan will apply to the extent that they would have applied if the Employee had not taken military leave and their coverage had been continuous under this Plan. The eligibility Waiting Period will be waived. (This waiver of limitations does not provide coverage for any Illness or Injury caused by or aggravated by the Employee's military service, as determined by the VA. For complete information regarding an Employee's rights under the Uniformed Services Employment and Reemployment Rights Act, Employees should contact their Employer).

DEFINITIONS

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used.

Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan. The terms are capitalized to highlight their use.

ABA / IBI / AUTISM SPECTRUM DISORDER THERAPY - Intensive behavioral therapy programs used to treat Autism Spectrum Disorder are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

ACCIDENT - An Injury which is:

1. Caused by an event which is sudden and unforeseen; and
2. Exact as to time and place of occurrence.

ADA - The American Dental Association.

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

AHA - The American Hospital Association.

ALLOWABLE EXPENSES - The Reasonable and Customary charge for any Medically Necessary, and eligible items 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, 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 instead of 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.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as an Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

AMA - The American Medical Association.

AMBULATORY SURGICAL CENTER - A specialized facility or a facility affiliated with a Hospital which is approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or licensed in

accordance with the applicable laws in the jurisdiction in which it is located and is established, equipped and operated primarily for the purpose of performing surgical procedures on an ambulatory basis.

APPROVED CLINICAL TRIAL - A phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The 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 Covered Person 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.

BIRTHING CENTER - A specialized facility or a facility affiliated with a Hospital which:

1. Provides twenty-four (24) hour a day nursing service by or under the supervision of registered graduate nurses (R.N.) and certified nurse midwives.
2. Is staffed, equipped and operated to provide:
 - a. Care for patients during uncomplicated Pregnancy, delivery, and the immediate postpartum period.
 - b. Care for infants born in the center who are normal or have abnormalities which do not impair function or threaten life.
 - c. Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life, pending transfer to a Hospital.

CALENDAR YEAR - For the purposes of this Plan, a length of time beginning on January 1 and ending on December 31.

CERTIFIED IDR ENTITY - shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) - A person who:

1. Is a graduate of an approved school of nursing and is duly licensed as a Registered Nurse.
2. Is a graduate of an approved program of nurse anesthesia accredited by the Council of Certification of Nurse Anesthetists or its predecessors.
3. Has been certified by the Council of Certification of Nurse Anesthetists or its predecessors.
4. Is recertified every two (2) years by the Council on Recertification of Nurse Anesthetists.

CHILD - The Employee’s natural Child, any stepchild, or any other Child for whom the Employee has been named legal guardian. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee’s physical custody in anticipation of adoption. “Child” shall also mean 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. A “legal guardian” is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

CHIP - 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 - 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.

CLAIMS ADMINISTRATOR – Personify Health Solutions, LLC (aka HealthComp Integrated Solutions, LLC)

CLEAN CLAIM – A claim 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 or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

CODE - The Internal Revenue Code of 1986, as amended from time to time, and the regulations thereunder.

CO-INSURANCE - That portion of Covered Medical Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the Deductible which are to be paid by the Employee.

COMMON-LAW MARRIAGE - A partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

COMPANY - Moffat County.

CO-PAYMENT - That portion of Covered Expenses which must be paid by or on behalf of the Covered Person incurring the expense.

COSMETIC SURGERY - Surgery that is intended to improve the appearance of a patient or preserve or restore a pleasing appearance. It does not mean surgery that is intended to correct normal functions of the body. This does not include reconstructive surgery resulting from an Illness or Injury.

COVERED EXPENSE(S) - A Reasonable and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one (1) treatment option is available, and one (1) option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

COVERED PERSON - Any Employee, Dependent, or individual that is covered under the Plan through COBRA continuation who is eligible for benefits (and enrolled) under the Plan.

CUSTODIAL CARE - Custodial Care shall mean care or confinement designated principally for the assistance and maintenance of the Covered Person, in engaging in the activities of daily living, whether or not Disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

DEDUCTIBLE - The amount of Covered Expenses that a Covered Person must pay before he can receive a benefit payment under the Medical and/or Dental Expense Benefits. However, certain covered benefits may be considered Preventive Care and paid first (1st) dollar.

DENTIST - A duly licensed Dentist practicing within the scope of his license and any other Physician furnishing any dental services which he is licensed to perform.

DENTAL HYGIENIST - A person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of Dental Hygiene, and who works under the direct supervision and direction of a Dentist.

DEPENDENT - A Dependent is a person who fits one (1) or more of the following categories:

1. Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom you have obtained a legal separation or divorce or who no longer meets the definition of a common-law marriage or civil union spouse. Documentation on a Covered Person's marital status may be required by the Plan Administrator.
2. A Dependent Child until the Child reaches his or her 26th birthday. The term "Child" includes the following Dependents:
 - a. A natural biological Child;
 - b. A stepchild;
 - c. A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age twenty-six (26) as of the date of such placement;
 - d. A Child under your (or your spouse's) Legal A as ordered by a court;
 - e. A Child who is considered an alternate recipient under a Qualified Medical Child Support Order

A Dependent does not include the following:

- a. A foster Child;
- b. A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
- c. A grandchild;
- d. A Domestic Partner;
- e. A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
- f. Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

DEVELOPMENTAL DELAYS - Means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

DOMESTIC PARTNER - An unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is

at least eighteen (18) years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

DIALYSIS FACILITY - A facility (other than a Hospital) whose primary function is the provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

DIALYSIS SERVICES - Dialysis services, prescriptions, supplies and the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or any other appropriate covered Provider. End Stage Renal Disease (**ESRD**) is a condition which the kidneys no longer function normally. Usually in End Stage Renal, the kidneys are functioning at less than 10% of their normal capacity. When kidney failure occurs, dialysis (a mechanical process that performs the work of the kidneys) or kidney transplant is usually needed.

DISABLED -

1. The Covered Person's complete inability as an active Employee, to perform any and every duty pertaining to his occupation or employment or for any occupation for wage or profit, or
2. The Covered Dependent's complete inability to perform the normal activities of a person of like age and sex, or
3. The Covered Person's complete inability, as a retired Employee, to perform the normal activities of a person of like age and sex.

DURABLE MEDICAL EQUIPMENT - Only that equipment and those supplies that:

1. Are primarily and customarily used to serve a medical purpose.
2. Would not be generally useful to a person in the absence of an Illness or Injury.
3. Are designed for repeated use.
4. Either:
 - a. Are Medically Necessary to:
 - i. Treat an Illness or Injury.
 - ii. Effect improvement of a Covered Person's medical condition.
 - iii. Arrest or retard deterioration of a Covered Person's medical condition.
 - b. Are alternatives to chair or bed confinement.

A cochlear implant is not considered Durable Medical Equipment.

ELECTIVE SURGERY - Surgery that is not emergency in nature or is not performed to correct a life-threatening situation.

EMERGENCY DENTAL CARE - An urgent, unplanned diagnostic visit and/or alleviation of acute or unexpected Dental condition.

EMERGENCY MEDICAL CARE - The initial treatment, including necessary related diagnostic services, of the unexpected and sudden onset of a medical condition manifesting itself by symptoms severe enough that the absence of immediate treatment could result in serious and/or permanent medical consequences.

EMERGENCY SERVICES - shall mean, with respect to an Emergency Medical Condition, the following:

1. An appropriate 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 or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the

patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.

EMPLOYEE - The word "Employee" as used herein shall mean any person employed and compensated for services by the Company on a regular full-time permanent basis.

EXPERIMENTAL AND/OR INVESTIGATIONAL - 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:

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.

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

1. If the drug or device cannot be lawfully marketed without approval of the United States 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.
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.
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.
 - 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.
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.

FDA approved medications used for conditions other than those for which they received Food and Drug Administration (FDA) approval, when considered the standard of care and *not* part of a clinical study or in

conjunction with any experimental treatment. For the purposes of this Plan, Standard of Care is defined as, charges for any care, treatment, services or supplies that are approved or accepted as essential to the treatment of any Illness or Injury by the American Medical Association, United States Surgeon General, United States Department of Public Health, or the National Institute of Health (NIH), and recognized by the medical community as potentially safe and efficacious for the care and treatment of the Injury or Illness. (*Unless otherwise stated under the Approved Clinical Trial section or Covered Medical Expenses section*)

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

EXTENDED CARE FACILITY / SKILLED NURSING FACILITY -

1. A Skilled Nursing Facility, as the term is defined in Medicare, which is qualified to participate and eligible to receive payments under and in accordance with the provisions of Medicare, except for a Skilled Nursing Facility which is part of a Hospital, as defined,
2. An institution which fully meets all of the following tests:
 - a. It is operated in accordance with the applicable laws of the appropriate governmental authority where it is located.
 - b. It is under the supervision of a licensed Physician, or Registered Nurse (R.N.), who is devoting full-time to such supervision.
 - c. It is regularly engaged in providing Room and Board and continuously provides twenty-four (24) hour-a-day skilled nursing care of ill and injured persons at the patient's expense during the convalescent stage of an Injury or Illness.
 - d. It maintains a daily medical record of each patient who is under the care of a duly licensed Physician.
 - e. It is authorized to administer medication on the order of a duly licensed Physician.
 - f. It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for Alcoholics or drug addicts or the mentally ill.

GENDER DYSPHORIA - A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

1. A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
2. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
3. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
4. A strong desire for the primary and/or secondary sex characteristics of the other gender.
5. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
6. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
7. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- a. A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):
- b. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).

- c. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- d. A strong preference for cross-gender roles in make-believe play or fantasy play.
- e. A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
- f. A strong preference for playmates of the other gender.
- g. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
- h. A strong dislike of one's sexual anatomy.
- i. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

GENERIC DRUGS - Prescription drugs and prescription medicines which are not protected by a trademark.

GINA - 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.

GROUP HEALTH PLAN - Any plan or arrangement constituting a Group Health Plan under Section 607(l) of ERISA.

HOME HEALTH AIDE - A person who provides care of a medical or therapeutic nature and reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY - Is either:

- 1. An Agency that is certified to participate as a Home Health Care Agency under Medicare.
- 2. A Hospital that has a valid operating certificate and is certified by the appropriate authority to provide home health services.
- 3. An agency licensed as such, if such licensing is required, in the State in which such Home Health Care is delivered.
- 4. A public agency or private organization or subdivision of such that meets the following requirements:
 - a. It is primarily engaged in providing nursing and other therapeutic services.
 - b. It is duly licensed, if such licensing is required, by the appropriate licensing authority, to provide such services.
 - c. It is federally certified as a Home Health Care Agency.

HOME HEALTH CARE PLAN - A Home Health Care program, prescribed in writing by a person's Physician, for the care and treatment of the person's Illness or Injury in the person's home. In the Plan, the Physician must certify that an Inpatient stay in a Hospital, a Convalescent Nursing Home, or an Extended Care Facility would be required in the absence of the services and supplies provided as part of the Home Health Care Plan. The Home Health Care Plan must be established in writing no later than fourteen (14) days after the start of the Home Health Care. An Inpatient stay is one for which a Room and Board charge is made.

HOSPICE CARE -

- 1. A coordinated, interdisciplinary Hospice-provided program meeting the physical, psychological, spiritual and social needs of dying individuals, and
- 2. Consists of palliative and supportive medical, nursing and other health services provided through home or Inpatient care during the Illness to a Covered Person who has no reasonable prospect of cure and as estimated by a Physician, has a life expectancy of fewer than six (6) months; and consists of bereavement counseling for members of such Covered Person's immediate family.

HOSPICE CARE FACILITY - Is either:

1. A free-standing facility which is fully staffed and equipped to provide for the needs of the terminally ill (and their families).
2. An Inpatient facility which is part of a Hospital but designated as a Hospice unit or is an adjacent facility, administered by a Hospital and designated as a Hospice unit.

A Hospice Care Facility must be approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or must meet the standards of the National Hospice Organization (NHO) and the appropriate licensing authority, if such licensing is required.

HOSPITAL - A legally operated institution which meets either of these tests:

1. Is accredited as a Hospital under the Hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or is accredited by the proper authority in the country in which the hospital is located.
2. Is a Hospital, as defined, by Medicare, which is qualified to participate and eligible to receive payments under an in accordance with the provisions of Medicare.
3. Is supervised by a staff of Physicians, has twenty-four (24) hour-a-day nursing services, and is primarily engaged in providing either:
 - a. General Inpatient medical care and treatment through medical, diagnostic and major surgical facilities on its premises or under its control.
 - b. Specialized Inpatient medical care and treatment through medical and diagnostic facilities (including x-ray and laboratory) on its premises, or under its control, or through a written agreement with a Hospital (which itself qualifies under this definition) or with a specialized provider of these facilities.
 - c. A psychiatric Hospital primarily engaged in diagnosing and treating mental illness, if it meets all of the requirements set forth in clause (a) other than the major surgery requirement.
 - d. A free standing treatment facility, other than a Hospital, whose primary function is the treatment of Alcoholism or drug abuse provided the facility is duly licensed by the appropriate governmental authority to provide such service.
 - e. A rehabilitative Hospital which is an institution operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed, and which meets all of the requirements of an accredited Hospital.

In no event will the term "Hospital" include a nursing home or an institution or part of one which:

- a. Is primarily a facility for convalescence, nursing, rest, or the aged, or
- b. Furnishes primarily domiciliary or Custodial Care, including training in daily living routines, or
- c. Is operated primarily as a school.

ILLNESS - A bodily disorder, disease, Pregnancy, or mental infirmity. All bodily injuries sustained by an individual in a single Accident or all Illnesses which are due to the same or related cause or causes will be deemed one Illness.

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.

INDEPENDENT LABORATORY - A freestanding facility offering radiology and pathology services which is not part of a Hospital and is licensed by the proper authority in the State in which it is located.

INJURY - An unforeseen happening to the body, requiring medical attention, including all related symptoms and recurrent conditions resulting from the Accident.

INPATIENT - A person receiving Room and Board while undergoing treatment in a Hospital, Hospice or other covered facility.

INTENSIVE CARE UNIT - A section, ward or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by professional nurses or other highly trained personnel, excluding any Hospital facility maintained for the purposes of providing normal post-operative recovery treatment or services.

LEARNING DISABILITY - A group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

LEAVE OF ABSENCE - A period of time during which the Employee does not work but which is of stated duration and after which time the Employee is expected to return to active full-time work. A Leave of Absence is generally requested by an Employee and approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

LEGAL SEPARATION or LEGALLY SEPARATED - An arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LICENSED PRACTICAL NURSE/LICENSED VOCATIONAL NURSE - An individual who has received specialized nursing training and practical nursing experience and who is licensed to perform such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

LIFETIME - When used in reference to benefit maximums and limitations, "Lifetime" is understood to mean while covered under this Plan. Under no circumstances does "Lifetime" mean during the lifetime of the Covered Person.

MANIPULATION - The act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

MAXIMUM ALLOWABLE CHARGE - shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by , or multiplied by a percentage that the particular Provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care; or

- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

MEDICAL EXPENSE BENEFIT - After satisfaction of the applicable Deductible, benefits will be provided for Covered Expenses for an Illness or Injury in a Calendar Year.

MEDICAL RECORD REVIEW - 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.

MEDICALLY NECESSARY/MEDICAL NECESSITY - Health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person'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 Covered Person's sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person'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 Covered Person's sickness or Injury without adversely affecting the Covered Person's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of a sickness or Injury.
4. The Plan reserves the right to incorporate CMS 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 Covered Person is receiving or the severity of the Covered Person'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 necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary."

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

MEDICARE - Title XVIII of the Social Security Act of 1965, as amended from time to time, and the regulations thereunder.

MENTAL HEALTH PARITY ACT OF 1996 (MHPA) AND MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA), COLLECTIVELY, THE MENTAL HEALTH PARITY PROVISIONS - 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).
2. 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).
3. 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).
4. 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 shall mean any Illness 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. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

MORBID OBESITY - A Body Mass Index (BMI) that is greater than or equal to 40 kg/m². If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by, obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI greater than or equal to 35 kg/m² is applied. Morbid Obesity for a Covered Person who is less than nineteen (19) years of age means a BMI that falls above the 95th percentile on the growth chart.

NO-FAULT AUTO INSURANCE - The basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

NOTICE OR NOTIFICATION - The ability to reasonably ensure actual receipt of the materials and specifically includes the normal mailing through the U. S. Mail.

OCCUPATIONAL THERAPY - Treatment rendered as a part of a physical medicine and rehabilitation program to improve functional impairments where the expectation exists that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. Benefits are not provided for diversion, recreational and vocational therapies (such as hobbies, arts & crafts).

ORTHOTIC APPLIANCES, DEVICES AND CASTS - Services including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

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 Covered Person.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.

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.

OUT-OF-POCKET MAXIMUM - The maximum covered expense that a Covered Person or family must pay before the Plan pays a hundred percent (100%) of the balance of eligible medical expenses for such person or family for the remainder of the Calendar Year.

OUTPATIENT - When a Covered Person receives diagnosis, treatment or twenty-three (23) hour observation in a Hospital or treatment facility but is not admitted as an Inpatient.

PALLIATIVE FOOT CARE - The cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

PARTICIPANT - An Employee of the Plan Administrator who participates in the Plan.

PARTICIPATING HEALTH CARE FACILITY - shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

PHARMACY - Any licensed establishment in which the profession of Pharmacy is practiced.

PHYSICAL THERAPY - Treatment by physical means including modalities such as whirlpool and diathermy; procedures such as massage, ultrasound, manipulation and subluxation; as well as tests of measurement requirements to determine the need and progress of treatment. Such treatment must be given to relieve pain, restore maximum function, and to prevent disability following Illness, Injury or loss of body parts. Treatment must be for acute conditions where rehabilitation potential exists and the skills of a Physician or other professional are required.

PHYSICIAN - A medical doctor (M.D.), an osteopath (D.O.), a Dentist or dental surgeon (D.D.S., D.M.D.), a podiatrist (D.P.M.), a chiropractor (D.C.), a psychologist (Ph.D., Psy.D.) or an optometrist (D.O.) or other medical professional who is duly licensed under the laws of the appropriate governmental authority to practice medicine, to the extent they, within the scope of their license are permitted to perform the services provided by this Plan. (The term shall also include a Social Worker for the treatment of psychiatric disorders and Substance Abuse). A Physician shall not include the Covered Person or any close relative of the Covered Person.

PLAN - Moffat County Group Health Benefit Plan.

PLAN ADMINISTRATOR - The entity responsible for the day to day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other services related to the Plan.

PLAN DOCUMENT - The legal document according to which the Plan is administered and governed.

PLAN YEAR - For purposes of this Plan, a length of time beginning on January 1st and ending on December 31st.

POST-SERVICE CLAIM - Any claim that involves only the payment or reimbursement of the cost for medical care that has already been provided.

PRE-ADMISSION TESTING - X-rays, laboratory examinations or other tests performed in the Outpatient department of a Hospital or other facility prior to Outpatient treatment or to confinement as an Inpatient provided:

1. Such tests are related to the scheduled Hospital confinement.

2. Such tests have been ordered by a duly qualified Physician after a condition requiring such confinement has been diagnosed.
3. The Covered Person is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable, or under the directions of the attending Physician, or because there is a change in the patient's condition which precludes the confinement.

PREGNANCY - A physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an Illness for the purpose of determining benefits under this Plan.

PRE-SERVICE CLAIM - A claim that must be decided before a claimant will be afforded access to health care.

PROSTHETIC DEVICE - The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

1. Due to the growth or development of a Dependent Child; or
2. When necessary because of a change in the Covered Person's physical condition; or
3. Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

PROVIDER - An entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

PSYCHIATRIC DISORDER - Neuroses, psychoneurosis, psychosis, or mental or emotional disease or disorder of any kind.

PSYCHIATRIC TREATMENT - Treatment or care for:

1. A mental or emotional disease or disorder.
2. A functional nervous disorder.
3. Psychological effects of Substance Abuse.

QUALIFIED - A licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

QUALIFIED BENEFICIARY - Any Beneficiary who is a Qualified Beneficiary as defined under Section 607(3) of ERISA.

QUALIFYING PAYMENT AMOUNT - means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

REASONABLE AND CUSTOMARY - Fees limited to Covered Expenses which are identified as eligible for payment by the Plan Administrator in accordance with the terms of this Plan. "Reasonable and Customary" amounts may be determined and established by the Plan, at the Plan Administrator's discretion, using normative data such as, but not limited to, the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, amounts the Provider most often agrees to accept as payment in full either through direct negotiation or through a preferred provider organization ("PPO") network, the cost to the Provider for providing the services, average wholesale price (AWP) and/or manufacturer's retail pricing (MRP), the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, rates negotiated with the Plan, and/or Medicare reimbursement rates. The Plan Administrator may, in its discretion, take into consideration specific circumstances and negotiated terms when defining the payable amount.

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.

Furthermore, Reasonable and Customary shall be limited to those claims that, in the Plan Administrator's discretion, are services or supplies or fees for services or supplies that are necessary for the care and treatment of Illness or Injury not unreasonably caused by the treating Provider. Determination that fee(s) or services are therefore Reasonable and Customary will be made by the Plan Administrator, taking into consideration, but not 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 and Customary, 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 and Customary. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable and Customary 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 and Customary.

The Plan Administrator 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 Customary and therefore not eligible for payment by the Plan.

RECOGNIZED AMOUNT - shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

REGISTERED NURSE - A professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

RESIDENTIAL TREATMENT FACILITY - A facility (other than a hospital) whose primary function is the treatment of a mental or emotional disease or disorder, functional nervous disorder, the treatment of alcoholism, chemical dependency or drug addiction and which is approved by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) or is duly licensed by the appropriate governmental authority to provide such services.

ROOM AND BOARD - A Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated patient care and patient education.
4. Other conditions of occupancy which are Medically Necessary.

SOUND NATURAL TOOTH - A tooth which:

1. Is free of decay, but may be restored by fillings.
2. Has a live root.
3. Does not have a cap or a crown.

SPECIALTY DRUG(S) - High-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.

SPEECH THERAPY - Active treatment for improvement of an organic medical condition causing a speech impairment. Treatment must be either post-operative or for the convalescent stage of an Illness or Injury.

SPOUSE - The person who is married to the Employee while the Employee is covered under this Plan. Refer to the Plan Participation section for more specific details.

SUBSTANCE ABUSE - Any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as 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.

The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

SURGICAL CENTER - A licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- a. It provides drug services as needed for medical operations and procedures performed;
- b. It provides for the physical and emotional well-being of the patients;
- c. It provides Emergency services;
- d. It has organized administration structure and maintains statistical and medical records.

TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) - Pain, swelling, clicking, grinding, popping, dislocation, locking, malposition, bite discrepancies or other pathological conditions which create a loss or decrease of function in or around one or both of the jaw joints.

TERMINAL ILLNESS OR TERMINALLY ILL - A life expectancy of about six months.

TREATMENT PLAN - A Physician's or Dentist's report, on a form satisfactory to the Company, which:

1. Itemizes the medical or dental services recommended by him or her for the necessary and customary care of a Covered Person.
2. Shows his or her charge for each service.
3. Is accompanied by supporting pre-operative X-rays or other appropriate diagnostic materials as required by the Company.

URGENT CARE CLAIM - A claim for care that is needed if making a non-urgent care decision could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or would subject the claimant to severe pain that cannot be adequately managed without treatment.

WAITING PERIOD - An interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan.

WORKERS' COMPENSATION - A fund administered under any Workers' Compensation, Occupational Diseases Act or Law or any other act or law of similar purpose to which the Company contributes, which provides the Employee with coverage for job-related accidental injuries and illnesses.

HOW TO SUBMIT A CLAIM

MEDICAL CLAIMS

Every medical claim must include a Physician's statement specifying the nature of the Illness or Injury for which reimbursement is requested. The Claims Administrator will accept such a diagnostic statement on any form which the Covered Person's doctor prefers to use. ***WITHOUT A DIAGNOSIS, A COVERED PERSON'S CLAIM CANNOT BE PROCESSED.***

All bills, except those for drugs, must indicate the patient's full name, the nature of the Illness or Injury, the date(s) of service, the type(s) of service and the charge for each service and the name, address and tax identification number of the provider.

For reimbursement of prescription drug expenses under the Medical Expense Benefit Plan, Covered Persons should submit bills indicating the patient's full name, the name of the prescribing Physician, the prescription number and the name of the medication, the charge for each prescription and the date of each purchase.

When prescription drugs are purchased through the Prescription Drug Plan, a claim submission is not necessary. The Covered Person's only responsibility is to pay the applicable Co-payment / Coinsurance (as applicable) at the time he or she purchases the prescription.

Should there be a primary insurance carrier for a member of the Covered Person's family, it is important to submit a copy of the itemized claim with a copy of the primary carrier's Explanation of Benefits statement indicating payment or denial of the charges.

MEDICARE CLAIMS

A Medicare claim is submitted as previously explained; however, when a Covered Person submits the claim, they need to be sure to also submit the Explanation of Benefits (EOB) that they receive from Medicare. The Claims Administrator may be unable to accurately determine benefits payable under the Plan without the Medicare EOB.

WHERE TO SUBMIT A CLAIM

Itemized bills must be submitted to the address indicated on the Covered Person's health benefit ID Card.

CLAIMS REVIEW PROCEDURES

DEFINITIONS

ADVERSE BENEFIT DETERMINATION - Any of the following:

1. A denial in benefits.
2. A reduction in benefits.
3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
4. A termination of benefits.
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.
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

CLAIMANT - Any Covered Person or entity acting on his or her behalf, authorized to submit claims to the Plan for processing and/or to appeal an Adverse Benefit Determination.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION - 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.

INTRODUCTION

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

HEALTH CLAIMS

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Claims Administrator. The Plan Administrator may delegate to the Claims Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Claims Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Claims Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

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 Claimant 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 Internal Adverse Benefit Determination. If the Claimant receives notice of a Final Internal Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant 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 Claimant, 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 (4) types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

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 Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant 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, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

WHEN CLAIMS MUST BE FILED

Post-service health claims (which must be Clean Claims) must be filed with the Claims Administrator within twelve (12) months of the date charges for the service(s) and/or supplies 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 Claims Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with the industry standard claim form:

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. Any applicable pre-negotiated rate;
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

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

The Claims 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 Claims Administrator within forty-five (45) days (forty-eight (48) hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

TIMING OF CLAIM DECISIONS

The Plan Administrator shall notify the Claimant, 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 Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.
 - b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than twenty-four (24) hours after receipt of the claim.
 - c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than forty-eight (48) 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 Claimant 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 Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone,

5. Extensions:
 - a. Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
 - b. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (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 Claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 - c. Post service Claims. This period may be extended by the Plan for up to fifteen (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 Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

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

1. Information sufficient to allow the Claimant 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 Claimant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures;
6. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
7. Upon request, 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);
8. 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 Claimant, upon request);
9. 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 Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, upon request; and
10. 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 Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A one hundred eighty (180) day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a one hundred eighty (180) day timeframe;

2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.
4. 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. A review that takes into account all comments, documents, records, and other information submitted by the Claimant 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. Upon request, the identity 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. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim;
9. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant'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 Claimant's medical circumstances.
10. That a Claimant 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 Claimant to respond to such new evidence or rationale.

Requirements for First Level Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination.

Pre-service Claims.

Claims appeals received by the Claims Administrator listed on the ID Card shall be deemed filed.

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:
Claimants should refer to their identification card for the name and address of the utilization review administrator. All pre service claims must be sent to the utilization review administrator.
2. Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Personify Health Solutions, LLC (aka HealthComp Integrated Solutions, LLC)
18861 S. 90th Avenue #A
Mokena, IL 60448
(708) 799-7400

Claims appeals received by the Claims Administrator listed on the ID Card shall be deemed filed.

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's identification number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant 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.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant 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 Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours 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 thirty (30) days per internal 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 Claimant 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 Claimant 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. 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.
3. A reference to the specific portion(s) of the plan provisions upon which a denial is based.
4. Upon request, 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).

5. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided. 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 Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures.
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 Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, upon request.
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals and external review processes.
12. 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 United States 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

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.

REQUIREMENTS FOR SECOND LEVEL APPEAL

The Claimant must file an appeal regarding a Pre-service or Post-service claim and applicable Adverse Benefit Determination, in writing within sixty (60) days following receipt of the notice of the first level Adverse Benefit Determination.

TWO (2) LEVELS OF APPEAL

This Plan requires two (2) levels of appeal (Pre-service or Post-service) by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

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 Claimant or Beneficiary fails to meet the requirements for eligibility under the terms of a Group Health Plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

1. Any eligible 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; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.
2. An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.
3. 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 an 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 (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth (5th) 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;
 - 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 within the four (4) month filing period or within the forty-eight (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 Administrator to contract with, on its behalf) at least three 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 Administrator'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 seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (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.

DEEMED EXHAUSTION OF INTERNAL CLAIMS PROCEDURES AND DE MINIMIS

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the external review program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the external review program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the external reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

CLAIM 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 Reasonable and Customary and/or Medically Necessary, 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 Reasonable and Customary 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 Reasonable and Customary charge, in accord with the terms of this Plan Document.

Please refer to the section entitled "Claim Review and Audit Program" for information regarding Plan provisions related to the audit and adjudication of certain claims under the Claim Review and Audit Program.

AUTOPSY

Upon receipt of a claim for a deceased Claimant for any condition, sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

PAYMENT OF BENEFITS

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in United States Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

ASSIGNMENTS

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Claimant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Claimant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Covered Person of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Claimant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will 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 may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, 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 medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

NON UNITED STATES PROVIDERS

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non United States Provider." Claims for medical care, supplies, or services provided by a Non United States Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non United States Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non United States Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in United States currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than United States currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and

licensed entity authorized to so establish said exchange rates. The Non United States Provider shall be subject to, and shall act in compliance with, all United States and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

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 Claimant or Dependent on whose behalf such payment was made.

A Claimant, 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 thirty (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 Claimant 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 Claimant 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 health 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 thirty (30) days of discovery or demand or incur prejudgment interest of one and a half percent (1.5%) per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) 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 Claimant(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 Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Illness 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 Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

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 Claimant for any outstanding amount(s).

MEDICAID COVERAGE

A Claimant'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 Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, 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.

LIMITATION OF ACTION

A Claimant cannot bring any legal action against the Plan for a claim of benefits until ninety (90) days after all appeal processes have been exhausted. After ninety (90) days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within three (3) years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against 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.

BALANCE BILLING

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many situations, and the Plan has no control over Non-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Covered Person is responsible for payment of applicable Co-insurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CHOICE OF PROVIDERS

The Plan is not intended to disturb the Physician-patient relationship. Each Covered Person 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 Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Covered Person, 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.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Claims 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 and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member 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 may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Covered Person 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 Covered Person'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 Claims Administrator to pay claims.
9. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.
10. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
11. To perform each and every function necessary for or related to the Plan's administration.

AMENDING AND TERMINATING THE PLAN

This Plan was established for the exclusive benefit of the Employees with the intention it will continue 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). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's directors or officers (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Plan Covered Persons are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Covered Persons, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

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 Material Modification 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. If said Material Modification is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Modifications requirements.

NOTE: The Affordable Care Act (ACA) 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.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Summary of Material Reduction (SMR) is a type of SMM. 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.

If said Material Reduction is affected by amendment as described above, distribution of a copy of said written amendment, within all applicable time limits, shall be deemed sufficient notification to satisfy the Plan's Summary of Material Reduction requirements.

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.

MISCELLANEOUS PROVISIONS

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Covered Person 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, 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.

NON-DISCRIMINATION

No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her Dependent's/Dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her Dependent's/Dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

APPLICABLE LAW

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of any other applicable law.

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 Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

CLERICAL ERROR/DELAY

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Covered Persons due to such clerical error will be returned to the Covered Person; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Covered Person, the amount of overpayment may be deducted from future benefits payable.

CONFORMITY WITH APPLICABLE LAWS

Any provision of this Plan that is contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, exclusions or statutes of limitations. It is intended that the Plan will conform to the requirements of any other applicable law.

FRAUD

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a thirty (30) day notice period as described under The Affordable Care Act (ACA) and regulatory guidance. 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.

HEADINGS

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

PRONOUNS

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

WORD USAGE

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

NO WAIVER OR ESTOPPEL

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of

this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

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 Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

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

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and 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 Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

STATEMENTS

All statements made by the Company or by a Covered Person 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 Covered Person.

Any Covered Person 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 Covered Person 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

To the extent this provision does not conflict with any applicable law, 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 Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, 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.

HIPAA PRIVACY

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 or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available.

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.

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 the Plan 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.

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 for any of the following:

1. To carry out Payment of benefits; or
2. 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).

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.
3. Other Covered Entities: 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.

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. 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.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. 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.
6. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
7. 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).
8. 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 United States 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).
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or 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 Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the United States Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the United States Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights

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

1. **Request Restrictions:** The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. **Right to Receive Confidential Communication:** The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. **Right to Receive Notice of Privacy Practices:** The Covered Person 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 Officer Coordinator.
4. **Accounting of Disclosures:** The Covered Person has the right to request an accounting of disclosures the Plan has made of his or 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 Covered Person is entitled to such an accounting for the six years prior to his or 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 Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer Coordinator.
5. **Access:** The Covered Person 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 Covered Person requests copies, he or 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 Officer Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. **Amendment:** The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. **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.**

Questions or Complaints

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

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the United States Department of Health and Human Services.

Plan Contact Information

Contact Information:
Moffat County
1198 West Victory Way, Suite 111
Craig, CO 81625
Phone: 1-970-824-9108
Fax: Please contact Plan Administrator for a secure fax number

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 Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

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 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.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. 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.
7. 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.
 - ii. Director of Employee Benefits.
 - iii. Employee Benefits Department employees.
 - iv. Information Technology Department.
 - b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

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

Disclosure of 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.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor with contributions from Covered Persons and/or the Plan Sponsor, or are 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. Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

PLAN NAME

Moffat County Group Health Benefit Plan

TAX ID NUMBER

84-6000785

PLAN AMENDED AND RESTATED

January 01, 2025

PLAN YEAR ENDS

December 31

EMPLOYER INFORMATION

Moffat County
1198 West Victory Way, Suite 111
Craig, CO 81625
Phone: 1-970-824-9108

PLAN ADMINISTRATOR

Moffat County
1198 West Victory Way, Suite 111
Craig, CO 81625
Phone: 1-970-824-9108

AGENT FOR SERVICE OF LEGAL PROCESS

Moffat County
1198 West Victory Way, Suite 111
Craig, CO 81625
Phone: 1-970-824-9108

CLAIMS ADMINISTRATOR

Personify Health Solutions, LLC (aka HealthComp Integrated Solutions, LLC)
18861 S. 90th Avenue #A
Mokena, IL 60448
(708) 799-7400

SOURCE OF FUNDING

Self-Funded

PLAN STATUS

Non-Grandfathered

APPLICABLE LAW

Federal and other applicable law

PLAN YEAR

January - December

PLAN TYPE

Medical

Prescription Drugs

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.

Non-English Language Notice This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.