Plan Document and Summary Plan Description for the Health and Welfare Benefit Plan

- Medical and Prescription Drug Benefits
- Dental Benefits

Amended and Restated: 07/01/2016

Administered by:

CRESCENT
HEALTH SOLUTIONS

Introduction

Cherokee County, NC (the "Employer" or "County") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, dental benefits and serves as the Summary Plan Description (SPD) and Plan document for the Health and Welfare Benefit Plan ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: Cherokee County, NC, 75 Peachtree Street Murphy, NC, 28906, 828-837-2735.

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

Table of Contents

Introduction ..... **ii**
Plan Overview **1**
Your Eligibility 1
Eligible Dependents 1
Proof of Dependent Eligibility 2
When Coverage Begins 2
Look-back Measurement Method for Determining Full-time Employee Status 2
For You 3
For Your Dependents 3
Your Cost for Coverage 4
Wellness Benefit Incentive 4
Enrolling for Coverage 4
New Hire Enrollment 4
Late Entrant 5
Annual Open Enrollment 5
Effect of Section 125 Tax Regulations on this Plan 5
Qualifying Change in Status 6
Special Enrollment Rights 6
When Coverage Ends 7
Cancellation of Coverage 7
Rescission of Coverage 7
Coverage While Not at Work 8
If You Take a Leave of Absence – FMLA 8
If You Take a Military Leave of Absence 8
Your Medical Benefits **9**
Your Deductible 9
Deductible Accumulation 10
Your Co-payment 10
Your Coinsurance 10
Out-of-Pocket Maximum 10
Out-of-Pocket Accumulation 10
Maximum Allowed Amount (Reasonable/Usual and Customary Limits) 11
Summary of Medical Benefits 11
Eligible Expenses 15
For More Information 22
Expenses Not Covered 22
Precertification 26
Precertification - Pregnancy and Childbirth 26
Penalty for Noncompliance with Precertification 27
Case Management 27
Your Prescription Drug Benefits **29**
How the Plan Works 29
Managed Pharmacy Network 29
Coverage Categories and Your Co-payment 29
Prescription Drug Tiers 29
Using a Network Retail Pharmacy 30
If You Use an Out-of-Network Retail Pharmacy 30
Mail-Service Program 30
Prior Authorization and Limits 31
Specialty Medications 31
Covered Prescription Drugs and Supplies 31
Expenses Not Covered 32
For More Information 33
Medicare Part D Creditable Coverage 33
Your Dental Benefits **34**

Annual Deductible 34
Coinsurance 34
Maximum Benefit 34
Covered Services 34
Orthodontic Benefits 35
Summary of Dental Benefits 35
Dental Exclusions 37
For More Information 39
Administrative Information 40
Plan Sponsor and Administrator 40
Plan Year 40
Type of Plan 41
Identification Numbers 41
Plan Funding and Type of Administration 41
Claims Administrators 41
Agent for Service of Legal Process 42
No Obligation to Continue Employment 42
Severability 42
Payment of Benefits 42
Payment of Benefits to Others 42
Expenses 42
Fraud 43
Indemnity 43
Compliance with Federal Mandates 43
Non-discrimination 43
Future of the Plan 43
Claims Procedures 44
Time Frames for Processing a Claim 44
How to Appeal a Claim 47
Exhaustion Required 47
Coordination of Benefits 49
Non-Duplication of Benefits / Coordination of Benefits 49
How Non-Duplication Works 49
Determining Primary and Secondary Plans 49
Coordination with Medicare 50
Coordination with Auto Insurance Plans 50
For Maximum Benefit 51
Subrogation and Reimbursement 51
Right of Recovery 51
Right to Subrogation 51
Right to Reimbursement 52
Third Parties 52
When This Provision Applies To You 52
Your HIPAA/COBRA Rights 54
Health Insurance Portability and Accountability Act (HIPAA) 54
Continuing Health Care Coverage through COBRA 56
COBRA Qualifying Events and Length of Coverage 56
COBRA Notifications 57
Cost of COBRA Coverage 58
COBRA Continuation Coverage Payments 58
How Benefit Extensions Impact COBRA 58
When COBRA Coverage Ends 59
Definitions 60
Adoption of the Plan 67
APPENDIX A - Dialysis Treatment - Outpatient..... 68
APPENDIX B - Organ Transplant Coverage 71

Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- Retired Employee of the Employer up to age 65 or until eligible for Medicare with 30 years of service;
- On the regular payroll of the County; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the County, the following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the County payroll, as determined by the County, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; or
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan.

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include:

- a person enrolled as an employee under the Plan;
- any person who is in active military service;
- a former Spouse; or

- a person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the County, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you.

It is your responsibility to notify the County if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

When Coverage Begins

Look-back Measurement Method for Determining Full-time Employee Status

The County uses the look-back measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations.

The look-back measurement method applies to:

- All employees

The look-back measurement method involves three different periods:

- Measurement period
- Stability period
- Administrative period

The measurement period is a period for counting your hours of service. Different measurement periods apply to ongoing employees, new employees who are variable hour, seasonal or part-time, and new non-seasonal employees who are expected to work full time.

If you are an ongoing employee, this measurement period is called the "standard measurement period." Your hours of service during the standard measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the standard measurement period and any administrative period.

If you are a new employee who is variable hour, seasonal or part-time, this measurement period is called the "initial measurement period." Your hours of service during the initial measurement period will determine your eligibility for the Plan's health care benefits for the stability period that follows the initial measurement period and any administrative period.

If you are a new non-seasonal employee who is expected to work full time, the County will determine your status as a full-time employee who is eligible for the Plan's health care benefits based on your hours of service for each calendar month. Once you have been

employed for a certain length of time, the measurement rules for ongoing employees will apply to you.

The stability period is a period that follows a measurement period. Your hours of service during the measurement period will determine whether you are considered a full-time employee who is eligible for health care benefits during the stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of the County. There are exceptions to this general rule for employees who experience certain changes in employment status.

An administrative period is a short period between the measurement period and the stability period when the County performs administrative tasks, such as determining eligibility for coverage and facilitating Plan enrollment. The administrative period may last up to 90 days. However, the initial measurement period for new employees and the administrative period combined cannot extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee’s start date (totaling, at most, 13 months and a fraction of a month).

Special rules may apply in certain circumstances, such as when employees are rehired by the County or return from unpaid leave.

The rules for the look-back measurement method are very complex. Keep in mind that this information is a summary of how the rules work. More complex rules may apply to your situation.

The County intends to follow applicable IRS guidance when administering the look-back measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

- **For You**

Your health care coverage begins first day of the month following a full calendar month of employment and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan. However, if you return to work and were enrolled in COBRA Continuation Coverage immediately prior to your rehire date, you will be covered under the Plan as of your rehire date.

- **For Your Dependents**

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan’s next open enrollment period to enroll your new dependent for coverage.

A newborn child born while you are enrolled for medical coverage will not automatically be enrolled in the Plan. Coverage will be effective with the newborn’s date of birth, provided the

child is enrolled within 31 days of birth. A separate annual deductible and coinsurance will apply to charges incurred by the newborn child.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the County and you share in the cost of your health care benefits. Each year, the County will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Wellness Benefit Incentive

Cherokee County encourages all employees to participate in Health Management. Our Health Management program is administered by Crescent Health Solutions and includes precertification, case management and disease management programs.

As a benefit to employees and to encourage health awareness, employees may qualify for an incentive rebate for the completion of certain medical tests. In order to qualify for the rebate, an employee must have testing that includes a lipid panel, a fasting blood glucose test along with your height, weight and blood pressure measurements. This may be completed annually at the Cherokee County Health Department and will be covered at no cost once each year. The results will then be submitted to Crescent on your behalf. If you have this testing completed at your physician's office, you must submit the blood panel results along with your height, weight and blood pressure measurements to Crescent Health Solutions. You should fax your results to (828) 670-9159. You will be eligible to receive a $100 rebate from the County following:

- Completion of required medical tests and measurements;
- Receipt of your results by Crescent Health Solutions; and
- Meeting your $500 annual deductible.

If a medical condition is identified that would suggest an employee could benefit from participation in the Disease Management program, the employee is encouraged to take advantage of this benefit. Employees that actively participate in the Disease Management program receive diabetic testing supplies and diabetes medications with no co-pay.

Enrolling for Coverage

- **New Hire Enrollment**

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug and/or dental coverage, you will need to make your coverage elections by the deadline shown in your enrollment

materials. When you enroll in the Plan, you authorize the County to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

- **Late Entrant**

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after canceling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the County nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your County work location or home address that changes your overall benefit options and/or prices;
- employee's spouse's open enrollment period differs and employee needs to make changes to account for other coverage;
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However,

you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the date your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the County terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the County's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentations are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage

will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence – FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the County's FMLA Policy.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Summary of Medical Benefits chart below for more information.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the claims administrator for the network shown on your ID card.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the reasonable and customary limit or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. See the Summary of Medical Benefits chart below for additional information.

However, if you travel into an area that offers an in-network provider, and you choose not to use the in-network provider, then all services will be covered at the out-of-network level of benefits as described above.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a Plan year basis. (see page 4 for Wellness Benefit Incentive)

Consult the Summary of Medical Benefits chart for more information. Your medical deductible does not include:

- co-payments
- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

Deductible Accumulation

Each individual must meet the individual deductible before benefits are payable unless the family deductible is satisfied by one or more individuals, which will then satisfy the family deductible.

Both in-network and out-of-network charges will apply to the deductible amount.

Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Copayments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required copayments and if the deductible may need satisfied before copayments are applied.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. The Summary of Medical Benefits chart below shows the coinsurance levels for common medical services in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and copayments. It is calculated on a Plan year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and copayments become zero for the rest of the year – and the Plan pays 100% of covered expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts.

The following expenses do not apply toward your out-of-pocket maximum:

- Prescription drug co-payments
- penalties for failing to follow precertification procedures
- any expenses not covered under the Plan

Out-of-Pocket Accumulation

A family's combined expenses must meet the family out-of-pocket maximum before covered expenses are payable at 100% for any covered family member for the year. However, if a covered family member satisfies the plan's individual out-of-pocket maximum, his or her covered expenses will be payable at 100% for the year.

Your spending for covered out-of-network expenses counts toward the in-network out-of-pocket maximum. Likewise, your spending for covered in-network expenses counts toward the out-of-pocket maximum for out-of-network services.

Maximum Allowed Amount (Reasonable/Usual and Customary Limits)

If you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Summary of Medical Benefits

Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days which may be split between Network and Non-Network. **Plan year begins every July 1.**

	In-Network	Out-of-Network
Annual & Lifetime Maximum Paid Benefit (per participant)	No Maximum	No Maximum
Annual Deductible (applies to expenses below unless otherwise noted)	$500 / individual $1,500 / family	$1,000 / individual $3,000 / family
Annual Out-of-Pocket Maximum (includes deductible, medical plan copays and coinsurance)	$3,500 / individual $10,500 / family	$7,000 / individual $21,000 / family

	In-Network	Out-of-Network
Allergy Testing, Serum, and Treatment	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Allergy Shots	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Ambulance Service	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Ambulatory Surgical Center Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Anesthetics, Oxygen, Transfusions	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Chemotherapy Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Chiropractic Care Limited to 30 visits per plan year	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

	In-Network	Out-of-Network
Diagnostic X-rays and Lab Services (includes advanced radiological imaging) MRIs, CT and PET Scans performed on an outpatient basis require precertification.		
Performed in and billed by a physician's office	Plan pays 100% after co-payment up to maximum payment of $200 for primary care and $400 for specialist. Then deductible and co-insurance apply. Maximum benefit per visit: $500 for Primary Care and $1,000 for Specialist Care	Plan pays 60% Maximum benefit per visit: $500 for Primary Care and $1,000 for Specialist Care
Performed in and billed by an outside lab/facility	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Dialysis Treatment – Outpatient Please see Appendix A. Precertification required.	100% of Usual and Customary Charges after all applicable deductibles and coinsurance Refer to Dialysis Treatment Outpatient Description in Appendix A	
Durable Medical Equipment Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Emergency/Acute Care		
Hospital ER Room (copayment waived if for accident or if admitted)	Plan pays 80% (after $150 co-payment) Deductible applies	Plan pays 80% (after $150 co-payment) Deductible applies
Urgent Care Facility (Deductible does not apply In-Network)	Plan pays 100% (after $30 co-payment)	Plan pays 60% (after deductible)
Home Health Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospice Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospital Services		
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Hospital Services – Outpatient	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Infertility Treatment (includes services for the diagnosis of infertility only) $5,000 Lifetime Maximum	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

	In-Network	Out-of-Network
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Mental Health and Substance Abuse Treatment		
Doctor's office visits	$50 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $1,000 maximum payment per visit.	Plan pays 60% $1,000 maximum payment per visit.
Outpatient/Intermediate Care	Plan pays 100% (after $50 co-payment)	Plan pays 60% (after deductible)
Inpatient Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Newborn Care – Inpatient	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Organ Transplants Special precertification procedures apply.	See Appendix B for description of network, coverage and limitations.	
Private Duty Nursing Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Primary Care Physician - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	$25 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $500 Maximum payment per visit.	Plan pays 60% $500 Maximum payment per visit.
Specialist Physician – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies)	$50 copayment then 100% up to maximum payment of $200 for primary care and $400 for specialist including all labs and x-rays. Then deductible and coinsurance apply. $1,000 maximum payment per visit	Plan pays 60% $1,000 maximum payment per visit.

	In-Network	Out-of-Network
Prosthetics	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Radiation Therapy Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Reconstructive Surgery Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Routine Preventive Care/Wellness Benefits – Plan pays 100% up to maximum combined benefit of $500 (per participant per year) for services shown below.		
Routine Office Visits (periodic and screening exams)	Plan pays 100% (Up to a maximum benefit of $500, then deductible and co-insurance apply)	Plan pays 60% (after deductible)
Routine Gynecological Exam/Pap Smear and Mammogram	Plan pays 100% (Up to a maximum benefit of $500, then deductible and co-insurance apply)	Plan pays 60% (after deductible)
Routine Preventive Care for Infants and Children – Maximum does not apply.		
Well-Child Care	Plan pays 100%	Plan pays 60% (after deductible)
Immunizations	Plan pays 100% (after $25 co-payment)	Plan pays 60% (after deductible)
Well- Baby Care Office Visit	Plan pays 100%	Plan pays 60% (after deductible)
Immunizations	Plan pays 100% (after $25 co-payment)	Plan pays 60% (after deductible)
Routine Patient Costs relating to Approved Clinical Trials	Not Covered	Not Covered
Second Surgical Opinions – voluntary	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Skilled Nursing Facility Limit of 60 days per plan year (combined in- and out-of-network)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Sterilization Procedures	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Surgery		
Hospital Inpatient Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Outpatient Facility Precertification required.	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

	In-Network	Out-of-Network
Therapy Services - Performed in and billed by Physician's office. Performed at outpatient facility or inpatient. Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury). The following therapies are limited to combined maximum visits of 30 per plan year in- and out-of-network: Occupational Therapy and Physical Therapy. Precertification required for outpatient rehabilitation.		
Cardiac Rehabilitation Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Occupational Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Physical Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Pulmonary/Respiratory Therapy	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)
Speech Therapy Speech therapy limited to 30 visits per plan year (combined in- and out-of-network)	Plan pays 80% (after deductible)	Plan pays 60% (after deductible)

** A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.*

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above).

The following are common conditions and services for which expenses are typically paid:

- **Abortion** – includes charges for non-elective abortions. Covered only if the life of themother is endangered by the continued pregnancy; the pregnancy was the result of rape or incest;
- **Allergy testing and treatment** – includes allergy testing, serum and injections as shown above;
- **Ambulance** – includes medically necessary professional ambulance services. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was medically necessary. Includes charges for local ground or air transportation by a professional ambulance service.
- **Ambulatory Surgical Center** – includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Amniocentesis** – see Pregnancy

- **Anesthesia** – includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.)
- **Birthing Center** – includes services and supplies provided by a licensed Birthing Center in connection with a covered pregnancy.
- **Blood** – includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services.
- **Cardiac Rehabilitation** – see Therapy, Short-Term
- **Chemical Dependency** – see Substance Abuse
- **Chemotherapy** – includes medically necessary and appropriate drugs and services of a physician or medical provider; also includes initial purchase of a wig following chemotherapy (lifetime limit of one).
- **Chiropractic Care** – includes musculoskeletal manipulation by a licensed physician (M.D. or D.O.) or chiropractor (D.C.) to correct vertebral and/or joint related disorders, such as incomplete dislocation, misalignment, sprain or strain.
- **Circumcision**
- **Counseling**
- **Dental Care – General Anesthesia and Hospitalization Associated with Dental Procedures**

  General anesthesia services and related facility charges provided on conjunction with any (i.e., covered or excluded) dental procedure that is performed in a hospital or in an ambulatory surgery center are eligible for coverage under the medical benefit of a group health policy when one or more criteria below are met:

  - The patient is under the age of seven, with a dental condition that cannot be safely and effectively treated in a dental office; or
  - The patient is physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
  - The patient has a medical condition that the physician determines would place him/her at undue risk if the dental procedure is performed in a dental office. The procedure must be approved by the patient's physician**.**
- **Diagnostic Lab and X-Ray, Outpatient** – includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; also includes advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests;
- **Dialysis Services** – Please refer to Appendix A.
- **Durable Medical Equipment** –includes coverage for the rental (or purchase, if rental would be more costly) of durable medical equipment (including wheelchairs) required for therapeutic purposes, as prescribed by a covered provider and determined by the Plan to be medically necessary.

  Excludes replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional.
- **Emergency Room Visits** – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include

fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

Colds, sore throats, flu, and infections are examples of nonemergency's, although they may require urgent treatment.

- **Home Health Care/Nursing** – includes home visits by a staff member of a home health care or private duty nursing agency (including a person under contract or arrangement with the agency), or a licensed therapist, during which any of the following services are provided:
  - Part-time or temporary nursing care performed by an R.N. or a licensed practical nurse (L.P.N.)
  - Part-time or temporary care by a home health aide
  - Oxygen service

  To be covered, home health care must be provided according to a home health care program set up in writing by a doctor. The doctor must state that the patient is, for all practical purposes, confined at home and the medical condition requires home health care.

  To be covered, the home health care agency must:
  - meet standards set by Medicare;
  - be approved by the Plan; and
  - be approved by your area's health care planning agency (if applicable).

  Outpatient private duty nursing will be covered only when medically necessary.

  Contact the Plan for approval before arranging home health care services.
- **Hospice Care** – includes hospice services furnished to a terminally ill person after the date the person enters the hospice care program. Also includes bereavement counseling services incurred before the patient's death for the patient.

  To be covered, the hospice care program must:
  - meet standards set by the National Hospice Organization;
  - be approved by the Plan;
  - be Medicare approved; and
  - be directed by a doctor.

  If the program is required to be state licensed, certified, or registered, it also must meet that requirement. Contact the Plan for approval before arranging hospice care services.
- **Hospital Services** – include hospital charges for the following:
  - Room and board - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.
  - services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;

- services of nursing staff and other hospital staff providing care;
- emergency room services; and
- medically necessary services.

An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Infertility Diagnosis and Treatment** – includes services for the diagnosis of infertility (only). Limited to $5,000 Lifetime maximum.
- **Medical Supplies** – includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines** – includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Health** – coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- **Midwife** – includes services of a certified or registered nurse midwife when provided in conjunction with a covered pregnancy.
- **Newborn Care** – includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births.

  Services for a newborn child are covered only if the child is enrolled in coverage within 31 days of birth.
- **Occupational Therapy** – see Therapy, Short-Term
- **Organ and Tissue Transplants** – Please refer to Appendix B.
- **Orthotics** – includes orthopedic braces, casts, splints, trusses and other orthotics prescribed by a physician that are required for support of an injured or deformed part of the body as a result of a congenital condition or an accidental injury and medically necessary foot orthotics.
- **Podiatry** – includes treatment for bunions (when an open cutting operation is performed); toenails when at least part of the nail root is removed; or any required medically necessary surgical procedure on the foot. Excludes coverage for routine foot care or treatment of unstable or flat feet.
- **Pregnancy** – includes prenatal visits and routine pre- and post-partum care, routine ultrasounds, one amniocentesis test for genetic testing, hospital stays, or birthing center, and obstetric services provided by a doctor or certified nurse-midwife (working under the direction of a doctor) for pregnancy, childbirth, or related complications for you and your covered spouse only.

Maternity benefits may be provided even if the pregnancy began before covered under the Plan, as long as coverage is in effect when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid.

Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours.

- **Private Duty Nursing** – provided inpatient only when care is medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit.
- **Prosthetics** – includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have been lost due to an accidental injury, sickness or surgery. Also includes replacement of a prosthetic device due to a change in the patient's physical condition that makes the original device no longer functional.

  To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.
- **Radiation Therapy** – includes radium and radioactive isotope therapy.
- **Reconstructive Surgery** – includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

  Coverage also includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; also includes surgery required to repair a congenital absence or agenesis (lack of formation or development) of a body part.
- **Respiratory/Pulmonary Therapy** – see Therapy, Short-Term
- **Routine Preventive Care/Wellness Benefits** – covers routine preventive care that includes, but is not limited to:
  - routine physicals, in accordance with American Medical Association age-based guidelines, which include medical history, physical exam, prostate exam, proctosigmoidoscopic exam, colonoscopy, weight/height, blood pressure, cholesterol screening, urinalysis, blood glucose, and EKG, as medically appropriate;
  - women's preventive services;
  - a mammogram;
  - well baby/well child care provided for children through age 18; and
  - immunizations administered in a doctor's office or health care facility.

  Recommended services and procedures can be found at www.healthcare.gov/coverage/preventive-care-benefits/.

- **Second Surgical Opinions** – covers a second (or third) surgical opinion you voluntarily obtain before recommended surgery. Second opinions provide you with more information so that you can make an informed decision about whether to have surgery or follow another course of treatment.
- **Skilled Nursing/Sub-Acute Facility** – includes room and board and non-custodial nursing care provided under the treatment plan of a physician if the patient is confined as a patient in the facility. Successive periods of confinement for the same condition will be treated as a single period unless separated by 14 days.
- **Sleep Disorders** – includes services, supplies, medications, and testing related to the diagnosis and treatment of sleep disorders, such as insomnia, narcolepsy, sleep apnea, and parasomnias. Excludes sleep therapy treatments designed to modify behaviors or sleep habits.
- **Speech Therapy** – see Therapy, Short-Term
- **Sterilization** – includes voluntary sterilization procedures for employee and covered spouse only. Excludes reverse sterilization procedures.
- **Substance Abuse** – includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.
- **Surgery** – includes surgeries performed in a doctor's office, outpatient facility or hospital. However, payments for multiple surgical procedures or surgeries involving more than one surgeon or assistant will be paid based on the primary procedure and the number of procedures and individuals involved. Payments for assistant surgeons may be limited as well. Any procedure not integral to the primary procedure or unrelated to the diagnosis will not be covered.

  When an assistant surgeon is required to render technical assistance during an operation, the eligible covered expense will be limited to 20 percent of the covered expense for the surgical procedure.

  If multiple surgeries are performed at the same time by one surgeon, the eligible covered expense is the fee for the major procedure plus 50 percent of the R&C charge for additional procedures performed through the same incision.

  If multiple unrelated surgical procedures are performed by two or more surgeons, benefits will be based on the R&C charge for each surgeon's primary procedure. If two or more surgeons perform a surgery normally performed by one surgeon, benefits for all surgeons will not exceed the R&C charges allowed for the procedure.
- **Therapy, Short-Term** – includes the following rehabilitation therapy services provided on an outpatient basis:
  - Cardiac Rehabilitation Therapy – includes services provided under the supervision of a physician in an approved facility in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery, in order to restore physiological and psychological well-being to an individual

with heart disease. Must be initiated within 12 weeks after other treatment for the medical condition ends.

- Physical Therapy – Includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.
- Occupational Therapy - includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function;
- Pulmonary/Respiratory Therapy – includes services of a licensed respiratory or inhalation therapist, when prescribed by a physician as to type and duration for function improvement of chronic respiratory impairment;
- Speech Therapy – Includes services of a licensed speech therapist when prescribed by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or sickness (other than a learning or mental disorder);

Maintenance care is not covered under any category above.

- **TMJ / Jaw Joint Treatment** - includes medically necessary treatment of jaw joint problems such as temporomandibular joint syndrome and cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.
- **Treatment of the mouth, teeth and gums** - Charges for injury or care to the mouth, teeth, gums and alveolar processes will be covered charges under the Medical benefits only if that care is for the following oral surgical procedures:

  Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

  Emergency repair due to an injury to the sound natural teeth

  Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, Floor and roof of the mouth

  Excision of benign bony growths of the jaw and hard palate

  External incision and drainage of cellulitis

  Incision of the sensory sinuses, salivary glands or ducts

  Removal of impacted teeth

  Reduction of dislocations and excision of TMJs

No charges will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

No charges will be covered for hospital services and related expenses for dental treatment regardless of the age of the patient.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the claims administrator at the number listed on the back of your ID card.

Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

Alternative Treatments

- music therapy;
- massage therapy;
- charges for pain disorder services or treatment including, but not limited to biofeedback, aversion therapy, self-help programs, services rendered by a masseur/masseuse, health club membership fees, or any similar type program designed for pain disorders such as ultrasound-guided extracorporal shock wave therapy;
- acupuncture or acupressure treatments unless administered by a licensed physician;

Behavioral Exclusions

- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation or activity, assault, or felonious behavior or activity; this exclusion does not apply to an injury or sickness contracted as the result of domestic violence or a medical (both physical or mental) condition;
- services or expenses to treat an intentionally self-inflicted injury while sane or insane; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical or mental) condition;
- services, supplies, care, or treatment for an injury or sickness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm such as (but not limited to) skydiving, auto or powerboat racing, hang gliding, jet ski operating, rock climbing, or bungee or base jumping;
- services, supplies, care or treatment resulting from a participant's or covered dependent's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition);
- services, supplies, care or treatment resulting from a participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician. Expenses will be covered for injured participants other than the person using

controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition;

- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a serious illegal act which includes any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction results, or that a sentence for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required (does not apply if the injury resulted from an act of domestic violence or a medical (physical or mental health condition);
- charges for failure to keep a scheduled visit, telephone consultations between patient and doctor, or completion of claim forms;
- services, supplies, care, or treatment for an injury or sickness which occurred as the result of or was caused by engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance (does apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);
- smoking cessation programs (except as may be provided under eligible expenses);

Comfort/Convenience Items and Services

- custodial care/assistance with activities of daily living, whether in a residential care facility, skilled nursing facility, or at home, including help in walking, bathing, preparing meals and special diets, and supervising use of medication;
- personal convenience items or equipment including, but not limited to, radio/television rentals, air conditioners, humidifiers, air purification or heating units, exercise equipment, elastic bandages or stockings, non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines;

Counseling

- Diabetes and Nutritional Education;
- services of dieticians and/or nutritionists and nutrition programs;
- educational or vocational testing;
- ancillary services for learning disabilities or developmental delays;

Dental/Oral

- orthodontic treatments;
- charges for dental care provided by an active dental plan;
- routine dental care, except for services to correct damage to sound natural teeth due to an accident that happens while a person is covered under the Plan and as described above under eligible expenses;

Foot Care/Podiatry

- Charges for examinations or fittings for routine care and treatment;

Hearing/Vision

- hearing exams, hearing aids including related services or supplies or fitting exams except as may be covered under wellness benefits;
- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation or the special contacts necessary to treat keratoconus; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages except as may be covered under wellness benefits;
- expenses for radial keratotomy or any other surgery to correct nearsightedness or refractive errors;

Home Services/Nursing

- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living;
- respite care;

Hospital/Hospice Services

- any hospital stay that is not for the diagnosis or treatment of a sickness or injury;
- non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission;
- complications resulting from non-covered services (other than abortion);

Medical Supplies/Appliances

- replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional;

Non-Compliance

- all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice;

Physical Appearance

- services, supplies, or treatment primarily for weight reduction or treatment of obesity, including but not limited to gastrointestinal surgery, hormones, medications, exercise programs or use of exercise equipment, special diets or supplements, appetite suppressants, weight loss programs, and hospital confinements for weight reduction programs.
- services for cosmetic reasons, except for covered reconstructive surgery;
- expenses related to the care and treatment of hair loss (excluding wigs after chemotherapy if indicated under eligible expenses above);

Reproduction/Sexual

- abortion unless

- the life of the mother is endangered by the continued pregnancy
- the pregnancy was the result of rape or incest.

However, expenses incurred to treat complications arising after the performance of an abortion are covered;

- services, supplies, or treatment for transsexualism, gender dysphoria, or sexual assignment or change, including medications, implants, hormone therapy, surgery, or medical or psychiatric treatment;
- treatment of benign gynecomastia;
- dependent pregnancies;
- sterilization reversals;
- fertility treatments such as in-vitro fertilization, GIFT, fertility assistance, and other artificial insemination or impregnation procedures;
- diagnosis, care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity not related to organic disease (except as may be covered under the Prescription Drug benefit);
- genetic testing;

Services Provided by Another Plan

- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan;
- services for any condition, illness, or injury, or complication thereof arising out of or in the course of employment, when the participant or covered dependent is furnished care or services covered hereunder, or could or might have been furnished such care and services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law, or any other law or regulation of the United States, or of a state, territory or subdivision thereof, or under any policy of Worker's Compensation or occupational disease insurance, or according to any recognized legal remedy available to the participant or covered dependent;

Travel-Related Expenses

- travel and accommodation expenses unless provided above under the Plan for a particular service;
- expenses for care or treatment outside of the United States if travel was for the sole purpose of obtaining medical services;

All Other

- expenses resulting from complications of a treatment not covered by the Plan (other than abortion);
- services rendered by an unlicensed provider;
- services or supplies for sickness, defect, disease, or injury due to war or a warlike action in time of peace;
- services and supplies that are experimental or investigational, except as

provided for under eligible expenses;

- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
- any charges in excess of the maximum amount payable under the Plan for a particular service or supply (see “Maximum Allowed Amount” above);
- autopsies;
- services or supplies received before the patient is covered by the Plan;
- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate care for the injury or sickness;
- services performed by a person who ordinarily resides in the participant’s home or who is related to the participant and/or his covered dependents as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization (and certain other treatments) as shown in the Summary of Medical Benefits above. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed on the back of your ID card to precertify an admission or treatment:

- at least 48 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Please note that precertification is not a guarantee of payment. Please contact the claims administrator in order to determine if a procedure is covered under plan benefits.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. If/when the pregnancy confinement for the mother or newborn is expected to exceed these limits, precertification for such extended confinement is required. The Plan must also be notified before any hospital admission for complications that occur during the pregnancy.

Procedures requiring Pre-Certification

Non-emergency inpatient admissions and/or surgeries
Non-emergency inpatient, partial-day psychiatric services or behavioral health services, including chemical dependency
Extended Care Facility (any type), Home Health Care, Private Duty Nursing and Hospice
Non-emergency inpatient rehabilitation admission
Durable Medical Equipment (over $500)
Sleep Studies and related expenses
Chemotherapy and Radiation treatments
Dialysis – see APPENDIX A
Outpatient surgical procedures (excluding those done in the physician office), including all invasive procedures and non-invasive diagnostic procedures.
These could include:

- Cardiac Catheterization, PTCA
- CABG or pacemaker implantation
- Breast or other biopsy
- CT, MRI, MRA, HIDA, and PET scans
- ESWL (lithotripsy)
- Endoscopy (EGD. ERCP, colonoscopy)
- Oral or TMJ Surgery

Orthopedic procedures including arthroscopy or carpal tunnel repair
Outpatient rehabilitation including speech, occupational and physical therapy
Health Management should be notified of maternity services during the first trimester of pregnancy
Notification and request for retrospective certification must be made within 48 hours of emergency admission or surgery
Organ Transplants require special precertification procedures–see APPENDIX B

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by 25%. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan's appeal process.

Case Management

Through the case management program, you receive appropriate health care services for medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through

the Plan under special circumstances. Case Managers will assist to provide information so you can make informed choices about your treatment choices and offer assistance in coordinating and navigating care.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.caremark.com.

Coverage Categories and Your Co-payment

There are three tiers in the prescription drug Plan; each has a different co-payment that applies depending on where you have your prescription filled. The chart below shows your co-payment amounts, co-payment maximum out-of-pocket amounts, and any deductible. If your Plan has a deductible, you must satisfy the deductible before the Plan pays benefits.

Your Prescription Drug Coverage

	In-Network Retail Pharmacy (up to a 34-day supply)	Mail-Service Program (up to a 90-day supply)
	Co-Pay	Co-Pay
Generic	$10	$25
Preferred Brand Name	$30	$75
Non-Preferred Brand Name	$60	$150

Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. The co-payment for generic drugs is $10 per prescription for up to a 34-day supply. For generic drugs purchased through the mail service program, the co-payment is $25 per prescription for up to a 90-day supply.

NOTE: Generic Medications. Members pay the difference when the brand medication is requested by the patient as well as by the physician when a generic is available. If your

physician prescribes a generic medication and you agree, you will be charged the generic co-pay. If a generic alternative is available, but you wish to receive the brand name product, then you will pay the applicable brand co-pay, **PLUS the difference between the retail cost for the generic medication and the retail cost of the brand name medication.** You should consult with your physician to determine if a generic alternative is available and is right for your needs. It is your responsibility to request your physician to allow for substitutions at the time your prescription is written. If a generic alternative is not available, the applicable brand co-pay will apply.

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it. If you request brand-name when a generic drug is available, you will pay the difference between the generic and brand name drug and no limits will apply, if applicable. Your co-payment for formulary (brand-name) drugs at a network retail pharmacy is $30 per prescription for up to a 34-day supply. For formulary drugs purchased through the mail service program, the co-payment is $75 per prescription for up to a 90-day supply.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. Your co-payment for non-formulary drugs at a network retail pharmacy is $60 per prescription for up to a 34-day supply. For non-formulary drugs purchased through the mail service program, the co-payment is $150 per prescription for up to a 90-day supply.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. You will receive a prescription drug identification (ID) card from the Claims Administrator. Present this card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can

also be conveniently refilled by phone or by using Pharmacy Manager's Web site www.caremark.com.

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Claims Administrator. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Claims Administrator with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Claims Administrator.

If your prescription is authorized by the Plan, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact the Claims Administrator.

Specialty Medications

Certain drugs are considered "specialty medications" and may only be purchased through a network pharmacy, except as required in an emergency. The following are the therapeutic classifications of specialty medications under the Plan:

- Blood Modifiers
- Hemophilia
- Interferon
- IGIV
- Oral Oncologics
- Pulmonary Hypertension
- Other (as determined by the Plan)

For information on ordering specialty medications, dispensing limitations, and your required co-payment for these drugs, contact the prescription drug benefit claims manager.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Alcohol Swabs for diabetics only;
- Adapalene (Differin) – *Prior Authorization Required*;

- Prescription prenatal vitamins;
- Drugs to treat narcolepsy including Provigil;
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin) – *Prior Authorization Required;*
- Oral contraceptives;
- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational;

Expenses Not Covered

The following drugs and supplies, among others, are not covered under the Plan:

- Any prescription refilled in excess of the number specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- Drugs or supplies covered under Workers' Compensation or occupational disease law or any similar law;
- Drugs labeled "Caution—limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Medication administered in a doctor's office or health care facility (other than contraceptive-related medications);
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);
- Injectable Supplies (other than for Insulin);
- Anti-Wrinkling Agents (e.g., Renova);
- Drugs used for treatments that are cosmetic-related;
- Over-the-counter drugs and products unless specifically listed as covered expenses in the plan;
- Immunization agents or biological sera;
- Brand name ulcer medications;
- Injectable contraceptives and contraceptive devices (e.g. IUDs and diaphragms);
- Fertility drugs;
- All dosage forms of smoking-cessation aids, whether prescription type, or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- Growth Hormones;
- Vitamins and dietary supplements whether or not they are prescribed by a physician.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as “creditable coverage”. Since the Plan’s coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

Your Dental Benefits

The Plan provides dental benefits that cover services you receive from a licensed dentist. The Summary of Dental Benefits chart below shows the covered services under the Plan.

A dental charge is incurred on the date the service or supply is performed or furnished. However, there are times when one overall charge may be made for all or part of a treatment. In this case, the total charge will be apportioned to each separate visit or treatment. The pro-rata charge will be considered incurred as each visit or treatment is completed.

Annual Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is $25 per person; $75 per family. The annual deductible does not apply to Class A Services. The dental deductible is separate from any other deductible that may apply under the Plan.

Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. Your coinsurance is determined by the type of service you receive as shown in the chart below.

Maximum Benefit

The maximum annual benefit is $1,000 per person per plan year. There is also a separate individual maximum benefit of $1,000 per lifetime for orthodontia treatment.

Covered Services

In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.

A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the Claims Administrator shown on your ID card.

Orthodontic Benefits

All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. A separate deductible as shown in the chart below applies to orthodontia expenses and cannot be used to satisfy any other deductible. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in accordance with the approved treatment plan over a period of up to 8 calendar quarters.

Summary of Dental Benefits

Annual Maximum Benefit (per plan year)	$1,000 per person
Annual Deductible (per plan year)	$25/person $75/family
Orthodontia Maximum Benefit (per lifetime)	$1,000
Orthodontia Deductible (per plan year)	$25/person $75/family

Diagnostic and Preventive Care (Class A) Services	**Plan Pays**
Oral exams (limited to 2 per plan year)	100%
Bite-wing X-Rays (limited to 2 per plan year)	100%
Full mouth x-rays (limited to 1 per 3 year period)	100%
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per plan year)	100%
Topical fluoride applications (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Topical application of sealants on permanent molars (limited to 1 per plan year) (limited to dependent children under age 19)	100%

Diagnostic and Preventive Care (Class A) Services	Plan Pays
Space maintainers and their fitting (limited to 1 per plan year) (limited to dependent children under age 19)	100%
Emergency palliative treatment to relieve pain	100%

Therapeutic and Restorative (Class B) Services	Plan Pays
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Extraction of teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw (but excluding charges for removal of stitches or post-operative exams)	80%
Periodontics (treatment of the gums and support structures of the teeth)	80%
Root canals and other endodontic treatments	80%
General anesthetics and their administration in connection with oral surgery, Periodontics, fractures, and dislocations	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Recementing of inlays, crowns, and bridges	80%
Consultations with a specialist	80%

Major and Prosthodontic (Class C) Services	Plan Pays
Relining of full or partial dentures if done more than one year after initial installation	50%

Major and Prosthodontic (Class C) Services	Plan Pays
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	50%
Repair of crowns, bridgework, and removable dentures	50%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture, or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	50%
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	50%
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old	50%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old	50%

Orthodontia Benefits	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	50%

Dental Exclusions

The following list includes some common dental charges which are not covered under the Plan:

- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;

- Charges in excess of the maximum amount payable under the Plan (see “Maximum Allowed Amount”);
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse’s parent, child, brother, or sister;
- Correction of congenital conditions;
- Cosmetic services, including personalization or characterization of dentures, bleaching of teeth, facing on pontics or crowns posterior to the second bicuspid, or precision attachments;
- Crowns for teeth that are restorable by other means for the purpose of periodontal splinting;
- Crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, restoring the bite (occlusion) or that are cosmetic in nature;
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist;
- Duplicate prosthetic devices or other dental applications;
- Education and training in personal oral hygiene, dental plaque control, or dietary and nutritional counseling;
- Expenses for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics;
- Expenses for initial placement of a complete or partial denture or fixed bridgework if it involves replacement of one or more natural teeth missing or lost prior to the effective date of coverage;
- Expenses for any dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth);
- Expenses for facings on pontics or crowns posterior to the second bicuspid;
- Expenses for barrier technique or sterilization of dental equipment and supplies;
- Implants, including any appliances and/or crowns, and the surgical insertion or removal of implants;
- Occlusal analysis, occlusal adjustments, mouth guards or occlusal guards, or any similar take home item;
- Replacement of a lost, missing, or stolen prosthetic device or other dental appliance;
- Retreatment or additional treatment necessary to correct or relieve results of a previous treatment;
- Services or supplies which are covered by any employer’s liability laws;
- Services or supplies which are covered by any workers’ compensation or occupational disease laws;

- Services that do not meet the standards of dental practices, accepted by the American Dental Association;
- Treatment which is considered to be experimental by the dental profession;
- Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
- Treatment received before becoming covered under the Plan or after coverage terminates;
- Veneers (bonding of coverings to the teeth);
- Expenses for class C services for the first year covered under the plan.

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the Claims Administrator at the number listed on the back of your dental ID card.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

Cherokee County, NC is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number:

Cherokee County, NC
75 Peachtree Street
Murphy, NC 28906
828-837-2735

The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the County. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the County, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 56-6000285 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The County and employees both contribute to the Plan. The County will use these contributions to pay benefits to or on behalf of Plan Participants from the County’s general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using County contributions to pay for the cost of such benefit.

Claims Administrators

The Plan Administrator has contracted with the following County(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical/COBRA /Utilization Review /Dental

Claims Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.
Suite 215
Asheville, NC 28806
828-670-9145
www.crescenths.com

Prescription Drug Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.
Suite 215
Asheville, NC 28806
828-670-9145
www.caremark.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

County Manager
Cherokee County, NC
75 Peachtree Street
Murphy, NC 28906
828-837-2735

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the County to continue your employment or interfere with the County's right to terminate your employment, with or without cause.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned. If you receive care from a non-network provider, it is your responsibility to pay the non-network provider for the charges you incurred, including any difference between what you were billed and what the Plan paid. You may not assign your benefits under the Plan to a non-network provider without the County's consent. The County (or a Claims Administrator) reserves the right, in its discretion, to pay a non-network provider directly for services rendered to you. Direct payment to a non-network provider shall not be deemed to constitute consent by the County or waive the consent requirement for assigning benefits.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, are Plan expenses and will be paid from the general assets of the County.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the County, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the County will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The County expects that the Plan will continue indefinitely. However, the County has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The County may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that

apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. You may also appeal the Plan's decision to rescind your coverage due to fraud or intentional misrepresentation of material fact. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims

Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit, as you will not have exhausted your internal administrative appeal rights. Participants or claimants

must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the Plan will calculate normal benefits, then subtract payments made by other carriers, with combined payments totaling up to 100 percent of allowable charges. Any remaining benefit above 100 percent of charges that the Plan could have paid, but did not, will be placed in a credit reserve and be applied to future unpaid claims.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's County plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
  - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
  - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
  - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
  - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;

- any co-payment under the automobile coverage;
- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the County has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;
    - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
    - Workers' Compensation coverage; or
    - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how

characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. These rules are called the HIPAA Privacy Rules.

You will receive a “Notice of Privacy Practices” from the Administrator(s) and/or Insurer(s) that contains information about how your individually identifiable health information is protected under the HIPAA Privacy Rules and who you should contact with questions or concerns.

The HIPAA Privacy Rules apply to group health plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA. PHI is individually identifiable information created or received by HIPAA Plans that relates to an individual’s physical or mental health or condition, the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper or oral. When PHI is in electronic form it is called “ePHI.”

The HIPAA Plans may disclose PHI to the Plan Sponsor only as permitted under the terms of the Plan, or as otherwise required or permitted by HIPAA. The Plan Sponsor agrees to use and disclose PHI only as permitted or required by the HIPAA Privacy Rules and the terms of the Plan.

The HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose enrollment and disenrollment information to the Plan Sponsor. Also, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the information for the purposes of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending or terminating the Plan. “Summary Health Information” means information that summarizes the claims history, claims expenses or types of claims experienced by individuals covered under the HIPAA Plans and has almost all individually identifying information removed. The HIPAA Plans may also disclose PHI to the Plan Sponsor pursuant to a signed authorization that meets the requirements of the HIPAA Privacy Rules.

In addition, the HIPAA Plans (or an Insurer with respect to the HIPAA Plans) may disclose PHI to the Plan Sponsor for plan administration purposes. Plan administration purposes means administration functions performed by the Plan Sponsor on behalf of the HIPAA Plans, such as claims processing, coordination of benefits, quality assurance, auditing and monitoring. Plan administration purposes do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor or any employment-related actions or decisions.

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) disclosed to it by the HIPAA Plans (or an Insurer with respect to the HIPAA Plans), the Plan Sponsor will:

- Not use or further disclose the information other than as permitted or required by the Plan or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides PHI received from the HIPAA Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the HIPAA Plans any use or disclosure of PHI of which it becomes aware that is inconsistent with the permissible uses or disclosures;
- Make PHI available in accordance with the individual rights of access under the HIPAA Privacy Rules;
- Make an individual's PHI available for amendment, and incorporate any amendments, as required by the HIPAA Privacy Rules;
- Make available the information required to provide an accounting of disclosures to individuals, as required by the HIPAA Privacy Rules;
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the HIPAA Plans available to the Secretary of the Department of Health and Human Services for purposes of determining compliance with HIPAA's requirements;
- If feasible, return or destroy all PHI received from the HIPAA Plans that the Plan Sponsor still maintains in any form and retain no copies of this information when no longer needed for the purpose for which disclosure was made, except that, if this return or destruction is not feasible, limit further uses or disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure adequate separation between the HIPAA Plans and the Plan Sponsor is established.

In addition, the Plan Sponsor will reasonably and appropriately safeguard ePHI (other than enrollment/disenrollment information, Summary Health Information and information disclosed pursuant to a valid HIPAA authorization) that is created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the HIPAA Plans. The Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the HIPAA Plans;
- Ensure that adequate separation between the HIPAA Plans and the Plan Sponsor is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and
- Report to the HIPAA Plans any security incident of which it becomes aware.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the County is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

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

For more information about the Marketplace, visit www.HealthCare.gov.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

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

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to

the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the County within 60 days of the qualifying event. The Plan Administrator (or its designated

COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan.
- The individual becomes entitled to Medicare.
- The County terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the County.

Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.

Birthing Center

A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

Centers of Excellence

Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas-kidney, and bone marrow transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

Chiropractic Care

Services provided by a Chiropractor (D.C.) or licensed physician (M.D. Or D.O.) including office visits, diagnostic xrays, manipulations, supplies, heat treatment, cold treatment and massages.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Custodial Care

Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment

Equipment such as braces, crutches, hospital beds, etc, that is primarily and customarily used to serve a medical purpose that:

- can stand repeated use;
- generally is not useful to a person in the absence of an illness or injury;
- is appropriate for use in the home.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

A person who works for the County in an employer-employee relationship.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your County for at least one year; you have worked at least 1,250 hours during the previous 12 months; your County has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the County. You should contact the County with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is

basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information

Genetic information includes information about genes, gene products, and inherited characteristics that may derive from an individual or family member. This includes information regarding carrier status or information derived from laboratory tests that identify mutations in specific genes or chromosomes, medical examinations, family histories, or direct analysis of genes or chromosomes.

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Hospice

A licensed (if required by the state in which it is located) facility set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will

contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person. :

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- in accordance with standards of good medical practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the eligible diagnosis of the condition;
- not experimental or investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

NMHPA

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a Plan year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social

Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Skilled Nursing Facility

A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

Adoption of the Plan

The Health and Welfare Benefit Plan, effective 07/01/2005, as amended and restated herein, is hereby adopted as of 07/01/2016. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this 18th day of May, 2016.

BY: _____

TITLE: County Manager

APPENDIX A

CHEROKEE COUNTY, NC
PLAN DOCUMENT INSERT

DIALYSIS CARVE OUT AMENDED AND RESTATED JULY 1, 2015

1. **Dialysis Treatment - Outpatient**.

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after July 1, 2015, regardless when the expenses related to such claim

were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

APPENDIX B

CHEROKEE COUNTY, NC

PLAN DOCUMENT INSERT

ORGAN TRANSPLANT COVERAGE

AMENDED AND RESTATED 07/01/2015

Benefits are for Eligible Expenses incurred for the medical care and treatment of a Covered Person for services and supplies furnished in connection with the following Covered Organ or Tissue Transplant Procedures:

Transplant of bone marrow, heart, lung, double lung, heart and lung, liver, liver and kidney, kidney, liver, pancreas, pancreas after kidney, simultaneous pancreas and kidney, and intestine are covered.

Network Benefits will be provided through a specialized transplant network managed by Tethys Health Ventures (THV). For specific benefit questions or to access a covered Provider or Facility, please call the Pre-Certification number (888-771-0695) on your Transplant ID Card.

Pre-Authorization Requirement for Organ or Tissue Transplant

As soon as reasonably possible, but in no event more than (10) days after a (**Covered Person/Plan Participant**)'s Physician has indicated the (**Covered Person/Plan Participant**) is a potential transplant candidate, the (**Covered Person/Plan Participant**) or their Physician should contact Tethys Transplant Services toll free number at 1-888-771-0695 for referral to the Tethys Transplant Services Transplant Case Manager for evaluation and pre-authorization.

Transplant Benefit Period:

1. For all organ transplants (other than bone marrow), the Transplant Benefit Period will commence: 10 days prior to the Covered Transplant Procedure,

   and will terminate: 12 months after the Covered Transplant Procedure

2. For all bone marrow transplants, the Transplant Benefit Period will commence: 30 days prior to the Covered Transplant Procedure

   and will terminate: 12 months after the Covered Transplant Procedure

TRANSPLANT SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	In Network	Out Network
Covered Percent of the Eligible Expenses	100%	60%
Pre-Certification Penalty:	$5,000	Same as In Network

Maximum Benefit Amount per Covered Benefit Period

BENEFIT DESCRIPTION	In Network	Out Network
NMDP Search and Registry Benefit:	$15,000	$15000
Limited per search:	$2000	$2000
Maximum Organ Procurement Benefit Non-living Donor:	100%	Per Schedule
Maximum Organ Procurement Benefit Living Donor:	100%	Per Schedule

Out-of-Network Organ and Tissue Procurement Schedule of Benefits:

Transplant	Benefit
Lung	$17,500
Double Lung	not covered
Heart	$17,500
Liver	$22,500
Heart/Lung	$17,500
Pancreas	$25,000
Kidney/Pancreas	$25,000
Kidney	$17,500

Maximum Bone Marrow Harvesting Benefit:	100%	$10,000
Maximum Transportation, Lodging and Meals Benefit:	$10,000	$10,000

Expenses for Air Ambulance Services are limited under the Air Ambulance Benefit Maximum and not this Benefit Maximum.

Maximum Daily Benefit for Lodging during Recipient Hospital Confinement:	$200	$200

BENEFIT DESCRIPTION	In Network	Out Network
Maximum Daily Benefit for Meals will be paid as a per diem without need for documentation while the Recipient is Confined in the participating Transplant Hospital:	$50	None
Maximum Air Ambulance Benefit:	$10,000	$10,000
Maximum Private Duty Nursing Benefit:	$10,000	$10,000
Maximum Transplant Evaluation Benefit:	100%	$500
Maximum Daily Outpatient Treatment Benefit:	100%	$150
Maximum Hospital or Skilled Nursing Facility Confinement Benefit: For Organ and Allogeneic Tissue Transplants and for Autologous Bone Marrow Tissue Transplants for the following conditions: Neuroblastoma, Hodgkin's Disease, Non-Hodgkin's lymphoma, Acute lymphocytic lymphoma, and Acute non-lymphocytic lymphoma.		
First consecutive 30 days	100%	$2000 per day
On or After 31 days	100%	$1700 per day
For all other Autologous Tissue Transplants		
First consecutive 30 days	100%	$1500 per day
On or After 31 days	100%	$850 per day
Maximum Surgical Benefit for Organ or Tissue Transplant:	100%	$10,000
Maximum for Physician Benefit Charges Including Surgery Benefit for Organ or Tissue Transplant:	100%	$10,000
Maximum Outpatient Treatment Benefit:	100%	$150 per day

DEFINITIONS

The Section on Definitions (pages 61-67) is amended to include:

AIR AMBULANCE means the conveyance of a Donor, organ, or patient by means of a private non-scheduled airline when the life of the patient or the viability of the organ to be transplanted may not be sustained by normal commercial means of transportation.

ALLOGENEIC BONE MARROW TRANSPLANT means a harvest of stem cells, whether from the bone marrow or the peripheral blood, from a third party Donor, for reinfusion into a Recipient. It includes the procedure known as allergenic peripheral stem cell transplant.

AUTOLOGOUS BONE MARROW TRANSPLANT means a harvest of stem cells, whether from the bone marrow or peripheral blood, to remedy damage to or suppression of the Covered Person's bone marrow or blood forming system resulting from the receipt of chemotherapy or radiation therapy. It includes the procedure known as autologous peripheral stem cell transplant.

COMPANION means a spouse, parent or person chosen by the Organ or Tissue Transplant Recipient to accompany the Recipient to the Hospital. If the Recipient is a minor, two Companions may accompany the minor to such Hospital.

CONSECUTIVE DAYS OF CONFINEMENT means that a Covered Person's stay in the Transplant Hospital or Transplant Facility is not separated by three (3) days of discharge from the inpatient department of the Transplant Hospital or Transplant Facility performing the transplant. In the case of a Hospital Facility or Transplant Facility that performs the Transplants in an Inpatient/Outpatient scheduled program, consecutive days shall be counted as those consecutive days within the inpatient and scheduled outpatient departments of the Hospital Facility or Transplant Facility performing the Transplant procedure. Consecutive stays will be separated by a three (3) day discharge from the inpatient and outpatient departments of the Hospital Facility or Transplant Facility performing the procedure.

DONOR means a live or cadaveric person donating an organ for the sole purpose of reinfusing, transfusing, or transplanting.

HARVEST AND PROCUREMENT. All medically necessary services related to the harvest and/or acquisition of solid organs, blood, bone marrow or peripheral stem cells, are covered services: *Provided, however*, that such harvesting or acquisition must be performed for the purpose of providing a Covered Transplant Procedure for a Member of a Plan which is covered by the Agreement. Such services include, but are not limited to: (1) surgical services for the harvest or acquisition of solid organs, bone marrow or peripheral stem cells; (2) hospitalization for up to two days for bone marrow puncture or for organ harvesting; (3) processing and storage of organs, bone marrow or peripheral stem cells for up to a thirty-day period; (4) purging or manipulation of bone marrow or blood; and (5) other services directly related to or part of harvest or acquisition. Notwithstanding the foregoing, in the case of a living

donor, services required by complications arising from the donation shall not be considered covered services.

IN-NETWORK HOSPITAL means any Hospital, Skilled Nursing Facility, or Provider with which Tethys Health Ventures or Our designee have a specific agreement or contract to perform a covered service or treatment at an agreed upon rate under the Organ/Tissue Transplant Benefit Plan.

LODGING AND MEALS means if the Recipient's Covered Transplant Procedure is performed at a participating Transplant Hospital, We will pay the Covered Charges incurred for lodging and meals incurred by the Recipient's companion(s) during the time the Recipient is confined to the participating Transplant Hospital and/or Extended Care Facility due to the Covered Transplant Procedure. Benefits for lodging and meals will be limited to the Lodging and Meals Daily maximum amount shown in the Schedule. Benefits will not exceed the Transportation, Lodging, and Meals maximum shown in the Schedule. Itemized receipts are required to support all such expenses.

ORGAN TRANSPLANT means the surgical removal from one person to another of any of the organs described in the Organ/Tissue Transplant Benefit Plan.

OUT OF NETWORK HOSPITAL means any Hospital, Skilled Nursing Facility or Provider that does not have a special agreement or contract with Tethys Health Ventures or Our designee to provide a covered service or treatment under the Organ/Tissue Transplant Benefit Plan.

RECIPIENT means a Covered Person who is the subject of a Covered Transplant Procedure.

TISSUE TRANSPLANT means the surgical transfer of Bone Marrow from one person to another (Allogeneic Bone Marrow Transplant) or from self to self (Autologous Bone Marrow Transplant).

TRANSPLANT EVALUATION means an evaluation by a Transplant Hospital or Transplant Facility to determine whether or not an organ or tissue transplant would be a Medically Necessary and appropriate treatment.

TRANSPLANT HOSPITAL or **TRANSPLANT FACILITY** means a Hospital that is equipped to perform an Organ or Tissue Transplant and is recognized in the medical community as specializing in the performance of Organ or Tissue Transplant.

TRANSPLANT PERIOD means the period of time described in the Organ/Tissue Transplant Benefit Plan. Two or more Transplant Periods will be treated as separate Transplant Periods if:

1. They are due to unrelated causes; or
2. They are due to related causes and the Transplant Periods are separated by 6 consecutive months, and the Covered Person is not confined at home or in a Transplant Hospital or Transplant Facility or Skilled Nursing Facility on the day immediately preceding the second Transplant Period.

TRANSPLANT RELATED SERVICES. All medically necessary services resulting from and/or directly related to a Covered Transplant Procedure are covered services. Such services include, but are not limited to: (1) services provided by the transplant facility; (2) hospital or skilled nursing facility services (including, but not limited to, room and board, pharmacy, chemotherapy, and radiation and other normal and customary services/supplies); (3) physician services; (4) nursing services, including private duty nursing; (5) outpatient treatment and follow-up; (6) speech, physical and/or occupational therapy; (7) anesthesia and anesthesia services; (8) radiology services; (9) laboratory services; (10) oxygen; (11) durable medical equipment; (12) blood, blood products, and blood transfusions; (13) dressings; and (14) pharmacy, including anti-rejection drugs. A service shall be considered "resulting from and/or directly related to" a Covered Transplant Procedure if: (1) the service in question is normally and customarily associated with, or otherwise necessitated by, the Covered Transplant Procedure and/or the post-transplant recovery process; or (2) the service in question is provided in response to, or is necessitated by, complications arising in whole or material part from the Covered Transplant Procedure.

TRANSPORTATION means if the Recipient's covered transplant procedure is performed at a participating Transplant Hospital that is in excess of 50 miles of the Recipient's home, We will pay the Eligible Expenses incurred by the Recipient and a Companion for transportation to and from the site of the participating Transplant Hospital where the Covered Transplant Procedure is performed. If the Recipient is a minor, transportation benefits will be provided for up to two persons who travel with such Recipient. Air flights are limited to 2 round trip flights per eligible companion. All trips and means of transportation must be approved by the transplant case manager. Benefits will be limited to the number of trips and Transportation, Lodging, and Meals Maximum indicated in the Schedule. Itemized receipts are required to support all such expenses.