

**PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION**

FOR

WAYNE COUNTY COMMISSIONERS

EMPLOYEE HEALTH BENEFIT PLAN

G - 4881

**PLAN EFFECTIVE DATE:
FEBRUARY 1, 2011**

Wayne County Commissioners hereby amends and restates its self-funded health care plan for the benefit of eligible Employees and their eligible Dependents.

The purpose of the Wayne County Commissioners Employee Health Benefit Plan (the "Plan") is to provide reimbursement for covered charges incurred as a result of Medically Necessary treatment for Illness or Injury of the County's eligible Employees and their eligible Dependents.

The County caused this instrument to be executed by its duly authorized officers effective as of the 1st day of February 2011.

WAYNE COUNTY COMMISSIONERS

By: _____

Title: _____

Date: _____

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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged Illness or Accident. The medical benefits available under the Wayne County Commissioners Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the County has attempted to provide the best coverage possible within the financial limits of both the County and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program. The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the County.

The County has selected **iPROCERT**, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact **iPROCERT** at **(800) 319-9416** at least 72 hours prior to any scheduled admission for a medical condition, Mental or Nervous Disorder, or Substance Abuse/Substance Dependence treatment. In case of an emergency Hospital admission or emergency surgery, **iPROCERT** must be notified within two working days following admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the **iPROCERT** pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the County incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.

IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources[®], for assistance. Group Resources[®] is always available to assist you with your questions.

We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our County.

Wayne County Commissioners

Wayne County Commissioners

PRIVACY AND SECURITY OF MEDICAL INFORMATION

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. The Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care Provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

The Plan does not operate by itself but rather is operated and administered by the County acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the County is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in "PRIVACY AND SECURITY OF MEDICAL INFORMATION" shall also be construed as references to the County to the extent necessary to carry out the actions of the Plan.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by Providers. The Plan may disclose your medical information to Providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care Providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care Provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service Provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Privacy and Security of Medical Information

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your medical information to your family members, relatives, or close personal friends, or any other person identified by you, if the medical information is directly relevant to the family member's, relative's or friend's involvement with your care or payment for your care.

Business Associates. The Plan contracts with individuals and entities (“business associates”) to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan’s financial records.

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers’ Compensation. The Plan may release your medical information for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Privacy and Security of Medical Information

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the County's premises; or
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

Privacy and Security of Medical Information

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

DISCLOSURES TO THE COUNTY. The Plan will disclose your medical information to the County for Plan administration purposes only upon receipt of a certification from the County that the Plan sets forth the permitted uses and disclosures of medical information by the County on behalf of the Plan, and that the County has agreed to the following assurances:

- The County will not further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
- The County will ensure that any agents, including subcontractors, to whom it provides medical information (including electronic medical information) received from the Plan agree to the same restrictions and conditions that apply to the County with respect to such information and agree to implement reasonable and appropriate security measures to protect the information;
- The County will implement administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic medical information that it creates, receives, maintains, or transmits on behalf of the Plan;
- The County will not use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the County;
- The County will report to the Plan any use or disclosure of medical information that is inconsistent with the permitted uses and disclosures, of which it becomes aware;
- The County will report to the Plan, within a reasonable time after the County becomes aware, any security incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic medical information;
- The County will report to the Plan any other security incident on an aggregate basis every quarter or more frequently upon the Plan's request;
- The County will make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;

Privacy and Security of Medical Information

- The County will, if feasible, return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible;
- The County will ensure that there is adequate separation between the Plan and the County (as described below) and that the separation is supported by reasonable and appropriate security measures;
- The County will make your medical information available to you (as described below);
- The County will make your medical information available to you for amendment and incorporate any amendment into your medical information (as described below); and
- The County will make available the information required to provide you an accounting of disclosures (as described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Effective February 17, 2010, if the Plan uses or maintains an electronic health record with respect to your medical information, you have a right to obtain a copy of such information in an electronic format and, if you so choose, direct the Plan to transmit such copy directly to another entity or person.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator.

Privacy and Security of Medical Information

Your request must state a time period which may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COUNTY. Only Employees of the County who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the County's Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan's privacy policies. In the event an individual fails to comply with the Plan's provisions regarding the protection of your medical information, the County will take appropriate action in accordance with its established policy for failure to comply with the Plan's privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

MEDICAL BENEFITS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below.

This Plan treats Mental or Nervous Disorders, Substance Abuse/Substance Dependence as any other illness. For benefits, please check below for the Provider who is performing the services.

The Plan Year Deductible and Out-of-Pocket will be waived when a Retiree or the eligible Dependent of a Retiree becomes Medicare eligible.

PLAN YEAR DEDUCTIBLE

PPO

Single..... \$500

Family \$1,500

NON-PPO

Single..... \$1,000

Family \$3,000

Eligible expenses are applied to both the PPO and Non-PPO Deductible. The maximum Deductible will never exceed the amount of the Non-PPO Deductible.

CARRY OVER DEDUCTIBLE Applies
Charges incurred in November, December, or January of a Plan Year and applied to the Deductible for that Plan Year will also apply to the Deductible for the current Plan Year.

COINSURANCE (After satisfaction of the Plan Year Deductible)

PPO 80%

NON-PPO 60%

Non-PPO Providers will be paid at the PPO rate subject to the PPO Deductible and PPO Out-of-Pocket under the following circumstances:

- 1) When radiology, anesthesiology, or pathology services are rendered by a Non-PPO Provider at a PPO facility;
- 2) When a Non-PPO Provider/facility is used in a Medical Emergency (see "DEFINITIONS") situation or for an Accidental bodily Injury; or
- 3) When the Covered Person is traveling or living outside the PPO network (Georgia or Florida).

OUT-OF-POCKET MAXIMUM (Not including Deductible)

PPO

Single..... \$1,000

Family \$2,000

NON-PPO

Single..... \$2,000

Family \$4,000

Medical Benefits

Eligible expenses are applied to both the PPO and Non-PPO Out-of-Pocket. The maximum Out-of-Pocket will never exceed the amount of the Non-PPO Out-of-Pocket. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that **Plan Year** will be paid at 100%. However, charges applied to the Deductible, Copays, penalties, amounts over Reasonable Charge or Customary Charge, and non-covered charges do not apply to the Out-of-Pocket Maximum.

ALLERGY TESTING/SERUM/INJECTIONS

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

AMBULANCE SERVICES

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS \$2,000,000

BIRTHING CENTERS

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

CHEMOTHERAPY/RADIATION/RENAL/PERITONEAL DIALYSIS (See “ONCOLOGIC PRE-AUTHORIZATION PROGRAM”)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

CHIROPRACTIC CARE (See Spinal Manipulation)

DIAGNOSTIC LAB & X-RAY (Hospital or freestanding facility. For discounted rates on Outpatient laboratory testing, see “QUEST LAB CARD PROGRAM.”)

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%
QUEST LAB CARD (Deductible waived) 100%

DURABLE MEDICAL EQUIPMENT/PROSTHETICS/ORTHOTICS

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%

EMERGENCY ROOM SERVICES

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies) 60%

HOME HEALTH CARE

PPO (Deductible applies)..... 80%
NON-PPO (Deductible applies)..... 60%
Maximum Visits Per Plan Year 120 visits

Medical Benefits

HOSPICE CARE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	\$3,000

INPATIENT HOSPITAL SERVICES (Must be pre-certified or eligible charges will be reduced by 50%)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

The Maximum Eligible Charge for Room and Board in a Hospital will be:

- a) for a semi-private room, the average semi-private room rate of the Hospital;
- b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be limited to 90% of the actual private room charge;
- c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

MATERNITY EXPENSE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OCCUPATIONAL THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

ORGAN TRANSPLANT

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT HOSPITAL SERVICES

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

OUTPATIENT SURGICAL CENTER

PPO (Deductible applies).....	100%
NON-PPO (Deductible applies).....	60%

PHYSICAL THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	40 visits

Medical Benefits

PHYSICIAN'S SERVICES

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

PRE-ADMISSION TESTING

PPO (Deductible waived).....	100%
NON-PPO (Deductible waived)	100%

PRIVATE DUTY NURSING

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Per Plan Year	\$2,500

RESPIRATORY THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

SECOND SURGICAL OPINION

PPO (Deductible waived).....	100%
NON-PPO (Deductible waived)	100%

SKILLED NURSING FACILITY CARE

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Days Per Plan Year	30 days

SPEECH THERAPY

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Maximum Visits Per Plan Year	30 visits

SPINAL MANIPULATION TREATMENT (Includes office visits, x-rays, manipulations, supplies, heat treatment, and cold treatment)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

STERILIZATION PROCEDURES (Tubal ligation/vasectomy)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%
Lifetime Maximum	\$2,500

Medical Benefits

SUPPLEMENTAL ACCIDENT BENEFIT (See “SUPPLEMENTAL ACCIDENT CHARGE BENEFITS”)

PPO (Deductible waived).....	100%
NON-PPO (Deductible waived)	100%

WELLNESS EXPENSE (Employee and spouse only - includes routine lab and x-ray (including but not limited to mammogram, pap smear, and prostate exam), routine bone density testing, routine colonoscopy, and routine exam)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

WIGS (After chemotherapy and/or radiation)

PPO (Deductible applies).....	80%
NON-PPO (Deductible applies).....	60%

WOMEN'S HEALTH AND CANCER RIGHTS ACT. Pursuant to the Women's Health and Cancer Rights Act of 1998, this Plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see subsection 21 of "ELIGIBLE CHARGES."

PRESCRIPTION DRUG PROGRAM

CVS/CAREMARK PRESCRIPTION DRUG PROGRAM. CVS/Caremark is able to provide many prescriptions for Covered Persons at a discounted price. Prescriptions may be purchased through the CVS/Caremark prescription drug program in two ways. Short-term prescriptions may be filled at local CVS/Caremark Network Pharmacies which will charge a flat fee (Copay) for up to a 30-day supply of medication. CVS/Caremark home delivery pharmacy service is a mail order prescription drug service which charges a flat fee (Copay) for a 90-day supply of prescription maintenance drugs, such as ulcer medication, insulin, thyroid medication, etc. When using the mail order option, Employees will need to request two prescriptions from their Physician, one for a two or three week supply to be filled by their local CVS/Caremark pharmacy, and another which can be mailed to the CVS/Caremark home delivery service for the remainder of their 90-day supply. Regardless of whether the Covered Person uses the drug card or mail order option, if the actual cost of the medication is less than the Copay, the Covered Person will only be responsible for the actual prescription cost.

PRESCRIPTION DRUG CARD PROGRAM

Copay For Each Prescription or Refill (30-day supply) (No Deductible)

Non-Preferred	\$60
Preferred	\$30
Generic Drugs	\$10
Specialty Drugs	20% of prescription cost up to a \$120 Copay

MAIL ORDER DRUG PROGRAM

Copay For Each Prescription or Refill (90-day supply) (No Deductible)

Non-Preferred	\$120
Preferred	\$60
Generic Drugs	\$20

The per prescription Copay is not eligible for reimbursement under the Plan.

Should the Covered Person purchase a non-preferred/preferred when generic is available (regardless of how the prescription is written) the Covered Person will be responsible for the non-preferred/preferred Copay and the difference between the non-preferred/preferred and the generic prescription cost.

Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Specialty Drugs means medications to treat chronic, complex conditions such as hepatitis C, multiple sclerosis and rheumatoid arthritis. Although the incidences of these and other serious diseases are being diagnosed more commonly, the medicines needed to treat such conditions are far from common. Specialty drugs may:

- 1) require nursing services or special programs to support patient compliance;
- 2) require disease-specific treatment programs;
- 3) have limited distribution requirements; or
- 4) have special handling, storage, or shipping requirements.

Some drug expenses which are not covered:

- * Drugs which can be obtained without a Physician's prescription;
- * Contraceptives (oral, injectables, etc.)
- * Therapy devices or appliances regardless of their intended use including:
 - hypodermic needles;
 - syringes;
 - support garments; or
 - other non-medical substances; and
- * Any drugs which are Experimental/Investigational (see "EXCLUSIONS AND LIMITATIONS" for further details).

This is not a complete list of drugs that are excluded. Please contact CVS/Caremark at (800) 519-8374 to determine specific drug coverage.

ONCOLOGIC PRE-AUTHORIZATION PROGRAM

A Covered Person who has a diagnosis of cancer (and his or her treating oncologist) must call **iPROCERT** at least three business days prior to the inception of a chemotherapy regimen. The number for **iPROCERT** is **(877) 512-6911**.

The Covered Person (or his or her treating oncologist) must provide **iPROCERT** with the proposed treatment regimen, including the names and NDC numbers of all drugs to be used in the treatment process. The Covered Person is responsible for informing the attending Physician of the requirements of the oncologic managed care procedure.

If there is a change to the treatment regimen (introduction / removal / replacement), then the Covered Person (or his or her oncologist) needs to again contact **iPROCERT** at least three business days prior to the beginning of the new treatment process.

The **iPROCERT** medical care counselor will contact the Physician to discuss the proposed treatment regimen and make a determination as to the eligibility of the treatment regimen under the Plan.

If the Covered Person fails to follow the Plan's procedures for pre-authorization of a chemotherapy regimen, the chemotherapy regimen may not be considered to be an eligible charge under the terms of the Plan.

QUEST LAB CARD PROGRAM

The “QUEST LAB CARD PROGRAM” has been added to your existing healthcare benefit package to save you money on outpatient laboratory tests. When you use Quest Lab Card, you pay nothing - no Deductible, no Coinsurance, and no Copay for Outpatient laboratory testing services covered by your healthcare plan.

Please note that it is your responsibility to request the Quest Lab Card Benefit.

How the Program Works

- 1) At your Physician’s office, show your identification card/Quest Lab Card to the office manager and the person collecting your specimens, and explain that you are part of the “QUEST LAB CARD PROGRAM.” You must verbally request that your specimens to be sent under the Quest Lab Card benefit to Quest Diagnostics. Your Physician or phlebotomist must indicate that you have Quest Lab Card on the paperwork that accompanies your specimens.
- 2) Your Physician’s office will collect your specimens and call for specimen pickup.
- 3) Quest Diagnostics will perform the tests and send the results to your Physician (usually the next business day).

If your physician is not able to collect the specimens in his office, please follow these instructions:

- 1) Request from your physician the test orders to take to one of the Quest Lab Card contracted collection sites. ONLY the sites listed on the Quest Lab Card website are available to collect for Quest Lab Card.
- 2) Site listings change, so you will find the most updated list, including hours, capabilities and any special instructions, on the website, www.LabCard.com, or by calling Quest Lab Card Client Services, (800) 646-7788, ext. 84.
- 3) The contracted collection site will send your specimens to Quest Diagnostics and the results will be sent directly back to your physician (usually within 24-48 hours).

The “QUEST LAB CARD PROGRAM” does not replace the benefits included in your current medical plan. It simply gives you the additional option of obtaining quality Outpatient lab testing at no cost.

Quest Lab Card Patient Options

- 1) Quest Lab Card Participant - if specimens are sent to Quest Lab Card and are covered by your healthcare plan:
 - Expenses are paid at 100%;
- 2) Quest Lab Card Non-Participant:
 - Regular benefits apply; and
 - You are responsible for Deductible, Coinsurance, or Copays.

SUPPLEMENTAL ACCIDENT CHARGE BENEFITS

This benefit applies when an Accident charge is incurred for care and treatment of a Covered Person's Injury and the charge is for a service delivered within 60 days of the date of the Accident, to the extent that the charge is not payable under any other benefits under the Plan (other than "MEDICAL BENEFITS").

BENEFIT PAYMENT

Benefits will be paid as described in "MEDICAL BENEFITS."

ACCIDENT CHARGE

An Accident charge is the lesser of the Reasonable Charge, Customary Charge, PPO allowance, or the amount charged for the following:

- 1) Physician services;
- 2) Hospital care and treatment;
- 3) diagnostic x-rays and lab tests;
- 4) local professional ambulance service;
- 5) surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations;
- 6) nursing service;
- 7) anesthesia;
- 8) covered prescription drugs; and
- 9) use of a Physician's office or clinic operating room.

SECOND SURGICAL OPINION PROGRAM

Certain Surgical Procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the “SECOND SURGICAL OPINION PROGRAM” fulfills the dual purpose of protecting the health of the Plan’s Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical Procedure. An elective Surgical Procedure is one that can be scheduled in advance that is not an emergency or of a life-threatening nature.

If the second Physician disagrees with the first Physician, benefits will be payable for the cost of a third opinion subject to the conditions listed above. Services must be performed within 90 days of original opinion. Second Surgical Opinions for cosmetic surgery, normal obstetrical delivery, and Surgical Procedures which require only local anesthesia are not covered.

The Covered Person may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available:

- 1) Appendectomy;
- 2) Hernia surgery;
- 3) Spinal surgery;
- 4) Cataract surgery;
- 5) Hysterectomy;
- 6) Surgery to knee, shoulder, elbow, or toe;
- 7) Tonsillectomy and adenoidectomy;
- 8) Mastectomy surgery;
- 9) Cholecystectomy (gall bladder removal);
- 10) Deviated septum (nose surgery);
- 11) Prostate surgery;
- 12) Tympanotomy (inner ear);
- 13) Hemorrhoidectomy;
- 14) Salpingo-oophorectomy (removal of tubes/ovaries);
- 15) Varicose vein ligation;
- 16) Coronary by-pass; and
- 17) Dilation and Curettage (D&C).

DEFINITIONS

As used in this Plan, the following words and phrases shall have the meanings indicated:

ACCIDENT means an incident resulting in Injury that occurs from external forces under unexpected circumstances, and which is in no way the fault of the victim. Injuries to teeth resulting from chewing or biting; as well as sprains and strains resulting from overexertion, excessive use, or overstretching will not be considered Accidental Injuries for purposes of medical benefit determination.

ADMINISTRATIVE SERVICE AGENT means the firm providing administrative services to the Plan Administrator in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Plan Administrator with any other information deemed necessary. Group Resources is the Administrative Services Agent for the Plan.

ANNUAL LIMIT ON ESSENTIAL HEALTH BENEFITS means the maximum amount that can be paid on behalf of a Covered Person during the period of time beginning on February 1 and ending on January 31 the following year.

COINSURANCE means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

COUNTY means Wayne County Commissioners or any affiliate which is participating in the Plan with the permission of Wayne County Commissioners.

COPAY means the amount which is required to be paid to a Provider by a Covered Person at the time of service.

COSMETIC TREATMENT means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

COVERED PERSON means an Employee or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

CUSTOMARY CHARGE means a charge for medical services, care, or supplies that does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a similarly situated person who receives such services or supplies within the same geographic locale.

The term “same geographic locale” means a city, county, or such greater area as may be necessary to establish a representative cross section of persons or organizations regularly furnishing the type of treatment, services, or supplies for which a specific charge is made.

The term “Customary” does not necessarily mean the actual charge made or the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, or hospital. The Plan will determine what the usual charge is, for any procedure, service, or supply, and whether a specific procedure, service, or supply is customary.

Customary Charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer’s retail pricing (MRP) for supplies and devices.

DEDUCTIBLE means the amount of eligible charges that a Covered Person must incur before benefits will be payable, as listed in “MEDICAL BENEFITS.” The Covered Person must meet a new Deductible each Plan Year. The Deductible will be applied separately to each Covered Person except when the family Deductible (shown in “MEDICAL BENEFITS”) has been met by the family. Once the family Deductible is met, no further Deductible for any Covered Person in that family will be required during that Plan Year.

DEPENDENT means a person who meets one of the following requirements:

- 1) is an Employee's lawfully married spouse who resides in the United States, possessing a marriage license who is not divorced from the Employee. The Plan Administrator may require documentation proving a legal marital relationship. The term will also include a common-law spouse if the Employee resides in a state that legally recognizes common-law spouses; or
- 2) is the Employee's:
 - a) child less than 26 years of age who resides in the United States, unless the child is eligible to enroll in an eligible employer-sponsored plan other than a group health plan of a parent; or
 - b) unmarried child age 26 or older who resides in the United States meeting all of the following conditions:
 - i) subject to a physical or mental impairment which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
 - ii) is unable to engage in any substantial gainful activity due to such physical or mental impairment; and
 - iii) for whom proof of such physical or mental impairment is submitted to the Plan Administrator within 31 days of the date coverage would have ended as a result of the child's age.

The term "child" includes a natural child, a stepchild, an adopted child at time of placement, a child placed with a Covered Person in anticipation of adoption, and a child for whom the Employee or Employee’s spouse is Legal Guardian if that child resides with the Employee and is dependent on the Employee in a regular parent-child relationship.

Notwithstanding the above, the term “child” also includes a child of the Covered Person whose coverage is ordered under a National Medical Support Notice and who otherwise meets the requirements above.

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

In the case of an individual whose parents are divorced, the individual may be considered the “child” of either parent.

The term "Dependent" does not include any person serving in the armed forces of any country; provided that if such a person is the child of the covered Employee who has not attained age 26, the foregoing shall apply only if such child is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

DURABLE MEDICAL EQUIPMENT means equipment which is:

- 1) able to withstand repeated use;
- 2) primarily and customarily used to serve a medical purpose;
- 3) not generally used by a person in the absence of Illness or Injury; and
- 4) appropriate for use in the home.

EMPLOYEE means any person employed on a regular basis by the County in the conduct of the County's regular business, who is regularly scheduled to work at least 30 hours per week, and who is classified by the County, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan. Employee shall also mean a Covered Person who was covered by the Plan prior to October 1, 1996 (under a County agreement) allowing 17 hours per week, as well as appointed or elected Employees who are on call 24 hours a day, seven days a week. The term "Employee" shall exclude any individual classified by the County, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the County's customary worker classification procedures, regardless of whether such classification is in error.

ESSENTIAL HEALTH BENEFITS, includes, in addition to any other services that are required to be treated as “Essential Health Benefits” under the Patient Protection and Affordable Care Act of 2010, the following general categories and items and services covered within the categories: ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

HOME HEALTH CARE means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:

- 1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
- 2) Occupational Therapy, Speech Therapy, and Physical Therapy which are provided by a Home Health Care Agency;
- 3) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.

Home Health Care is provided to a Covered Person in accordance with a Home Health Care plan only if:

- 1) the Covered Person was confined in a Hospital for at least three consecutive days and the Home Health Care begins within 14 days following this period of Hospital confinement; and
- 2) the Home Health Care is given for the same or related condition for which the Covered Person was hospitalized.

The term "Home Health Care" does not include:

- 1) services or supplies not included in the Home Health Care plan;
- 2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;
- 3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
- 4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
- 5) transportation.

HOSPICE means a public agency or private organization which meets all of the following requirements:

- 1) is primarily engaged in providing care to terminally ill patients;
- 2) provides 24-hour care to control the symptoms associated with terminal illness;
- 3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
- 4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
- 5) maintains central clinical records on all patients;
- 6) provides appropriate methods of dispensing drugs and medicines; and
- 7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:

- 1) custodial care;
- 2) care for drug addicts and alcoholics; or
- 3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:

- 1) a place of rest;
- 2) a place for the aged; or
- 3) a hotel or similar institution.

HOSPITAL means a place which meets all of the following requirements:

- 1) is accredited as a general hospital by the Joint Commission on Accreditation of Hospitals;
- 2) is open at all times;
- 3) is operated chiefly for the treatment of sick or injured persons as Inpatients;
- 4) has a staff of one or more Physicians available at all times;
- 5) provides 24 hour nursing services by Registered Nurses (R.N.s);
- 6) includes areas designed for diagnosis and major Surgical Procedures.

The term "Hospital" also includes:

- 1) a facility operating legally as a mental health Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; and
- 2) a facility operating primarily for the treatment of Substance Abuse/Substance Dependence if it meets these tests:
 - a) maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients;
 - b) has a Physician in regular attendance;
 - c) continuously provides 24-hour a day nursing service by a registered nurse (R.N.);
 - d) has a full-time psychiatrist or psychologist on the staff; and
 - e) is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse/Substance Dependence.

The term "Hospital" does not include a convalescent facility, nursing home, rest home, Skilled Nursing Facility or a facility chiefly operated for treatment of the aged.

ILLNESS means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which are due to the same cause or to a related cause or causes will be deemed to be one Illness.

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

INJURY means bodily Injury caused by an Accident and which results directly from the Accident and independently of all other causes.

INPATIENT means an individual confined as a registered bed patient in a Hospital, Skilled Nursing Facility or Hospice.

INTENSIVE CARE/CORONARY CARE/ACUTE CARE UNIT/BURN UNIT means a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This area must have:

- 1) facilities for special nursing care not available in regular rooms and wards of the Hospital;
- 2) special life saving equipment which is immediately available at all times;
- 3) at least two beds for the accommodation of the critically ill; and
- 4) at least one Registered Nurse (R.N.) in continuous and constant attendance 24 hours a day.

LEGAL GUARDIAN means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LIFETIME means the maximum benefit while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

MAXIMUM BENEFIT means the maximum amount payable for the period indicated for a Covered Person for all eligible charges incurred while covered under the Plan.

MEDICAL EMERGENCY means a sudden and unexpected onset of a medical condition requiring medical care which the patient secures immediately after the onset and, as a general rule, is a condition which would be life threatening or would cause serious impairment if immediate care were not received. A Medical Emergency includes poisoning, shock, and hemorrhage. The Plan may, at its own discretion, request satisfactory proof that a Medical Emergency or acute condition did exist. **Colds, flu, sore throat, or earaches are not medical emergencies.**

MEDICALLY NECESSARY means health care services, supplies, or treatments which are for the purpose of evaluation, diagnosis, or treatment of the Covered Person's Injury or Illness and are:

- 1) recommended, approved, or ordered by a Physician or Dentist exercising prudent clinical judgment, and clinically appropriate in terms of type, frequency, extent, site, and duration for the diagnosis or treatment of the Covered Person's Illness or Injury;
- 2) consistent with the patient's condition or accepted standards of good medical and dental practice;
- 3) not performed for the convenience of the patient or the Provider of medical and dental services;
- 4) no more costly than alternative interventions, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Illness or Injury without adversely affecting the Covered Person's medical conditions;
- 5) not conducted for research purposes; and
- 6) the most appropriate setting and level of services which can be safely provided to the Covered Person, considering the Covered Person's medical symptoms and conditions.

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

In addition, with respect to Mental or Nervous Disorders, Substance Abuse, and Substance Dependence, to be considered "Medically Necessary," the treatment, services, and/or supplies must not be (a) maintenance therapy or maintenance treatment, or (b) a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity.

MENTAL OR NERVOUS DISORDER: To be a Mental Disorder or Nervous Disorder, the disease or condition, regardless of whether the cause is organic, must be classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Mental or Nervous Disorder does not include Substance Abuse or Substance Dependence or any condition resulting therefrom.

MORBID OBESITY means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

NATIONAL MEDICAL SUPPORT NOTICE means a qualified medical support order and serves notice that the employee identified on the document is obligated by a court or administrative child support order to provide health care coverage for the child(ren) identified in it. The NMSN meets the requirements for a Qualified Medical Child Support Order (QMCSO) if the child support agency correctly completes it and if coverage for the child(ren) is or will become available. The NMSN is a QMCSO under the Employee Retirement Income Security Act (ERISA) section 609 (a)(5)(s).

OCCUPATIONAL THERAPY means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

OUT-OF-POCKET MAXIMUM means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not include the Deductible amount on this Plan, Copays, non-covered items, amounts over the Reasonable Charge or Customary Charge, and penalties.

OUTPATIENT means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

OUTPATIENT SURGICAL CENTER means any public or private establishment which:

- 1) has a staff of Physicians;
- 2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
- 3) provides continuous Physician and nursing services while patients are in the facility.

PHYSICAL THERAPY means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

PHYSICIAN means a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.), a Doctor of Podiatry (D.P.M.), a Doctor of Chiropractic (D.C.), an Audiologist, a Certified Registered Nurse Anesthetist (C.R.N.A.), a Licensed Physical Therapist (L.P.T.), a Midwife, an Occupational Therapist, an Optometrist (O.D.), a Physiotherapist, a Psychiatrist, a Psychologist (Ph.D.), a Speech and Language Pathologist, a Licensed Clinical Social Worker (L.C.S.W.), a Master of Social Work (M.S.W.), a Licensed Professional Counselor (L.P.C.), and any other practitioner of the healing arts who is currently licensed and regulated by a state or federal agency, and who is acting within the scope of his or her license, to the extent that his or her services are covered under this Plan.

The term "Physician" does not include a person who:

- 1) is the Covered Person receiving treatment; or
- 2) is a relative by blood or marriage of the Covered Person receiving treatment.

PLAN YEAR means each period of time beginning on February 1 and ending on January 31 of the following year.

PRE-ADMISSION TESTING means x-ray and laboratory examinations which:

- 1) are performed on an Outpatient basis;
- 2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
- 3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

PREFERRED PROVIDER ORGANIZATION (PPO) means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided.

Utilization of PPO network Providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the Providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at www.firsthealth.com.

PROVIDER means a Hospital, Physician, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as a covered expense in the Plan.

REASONABLE CHARGE means fee(s) for services or supplies which are Medically Necessary for the care and treatment of Illness or Injury not caused by the treating provider. When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered the "Reasonable Charge" for the treatment. The determination of whether a charge is a Reasonable Charge will consider, but will not be limited to, the findings and assessments of the following entities: (a) The national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable.

ROOM AND BOARD means the Hospital's charge for:

- 1) room and linen service;
- 2) dietary service, including meals, special diets, and nourishments; and
- 3) general nursing service.

SECOND SURGICAL OPINION means charges incurred on an Outpatient basis for Physician's fees, and related diagnostic tests to confirm that surgery is Medically Necessary. The Physician who provides the Second Surgical Opinion must be one who:

- 1) treats the type of condition for which surgery is advised;
- 2) is not scheduled to do the surgery; and
- 3) has no business or financial relationship with the Physician recommending or performing the surgery.

SKILLED NURSING CARE means those charges incurred for:

- 1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
- 2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:

- 1) that part or all of any nursing care that does not require the skills of an R.N.; or
- 2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:

- 1) is licensed according to state or local laws;
- 2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
- 3) includes areas for medical treatment;
- 4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
- 5) maintains daily health records for each patient;
- 6) has an agreement which provides for the services of a Physician;
- 7) has a suitable method for providing drugs and medicines to patients;
- 8) has an arrangement with one or more Hospitals for the transfer of patients;
- 9) has an effective utilization review plan;
- 10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
- 11) is not solely a place for:
 - a) rest, rehabilitation or custodial care;
 - b) the aged;
 - c) the treatment of drug addiction or Substance Abuse/Substance Dependence;
 - d) the treatment of alcoholism; or
 - e) those who are mentally disabled or who have mental disorders.

SOUND NATURAL TEETH means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

SPEECH THERAPY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.

SPINAL MANIPULATION means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SUBSTANCE ABUSE means the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

- 1) an inappropriate pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
 - a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);

- b) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
 - c) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct);
 - d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
- 2) the symptoms have never met the criteria for Substance Dependence for the class of substance.

SUBSTANCE DEPENDENCE means substance use history which includes the following: (1) Substance Abuse; (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

SURGICAL PROCEDURE includes, but is not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

TEMPOROMANDIBULAR JOINT (TMJ) SYNDROME means a jaw/joint disorder causing pain, swelling, clicking, and difficulties in opening and closing the mouth; and complications including arthritis, dislocation, and bite problems of the jaw.

TOTAL DISABILITY or TOTALLY DISABLED means an Injury or Illness which:

- 1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the County; and
- 2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and gender.

WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:

- 1) for which such person is not eligible; or
- 2) in excess of the maximum amount provided under any benefit for which the person is covered.

ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES:

All Employees in an eligible class.

Retired Employees age 55 and older with at least 25 years of full-time service, who were continuously covered under the Plan preceding retirement with Wayne County Commissioners. When the Retired Employee becomes eligible for Medicare, this plan will become secondary.

REQUIRED EMPLOYEE CONTRIBUTIONS:

Employees do contribute toward the cost of Employee and Dependent coverage.

Retired Employees do contribute toward the cost of Retired Employee and Dependent coverage.

The amount that Employees contribute is calculated by the Plan Administrator and is a portion of the cost of coverage under the Plan.

WAITING PERIOD. The period that begins with an Employee's first hour of service during his most recent employment with the Company and ends on the first day of the month following date of hire. For any Late Enrollee, as defined in the "WHEN COVERAGE BEGINS" section of the Plan, any period before the Late Enrollee's enrollment in the Plan is not a waiting period.

ELIGIBILITY FOR EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:

- 1) the effective date of the Plan; or
- 2) the first day of the month following date of hire.

OPEN ENROLLMENT means the period from January 1 through January 31 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the County may make changes to their coverage. Coverage under any newly elected option will take effect on February 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met. If an Employee does not complete and return a new election form prior to February 1 of each year, the previous year's coverage will remain in effect.

Benefit choices made during the Open Enrollment period will remain in effect until the first day of the following Plan Year unless a Covered Person experiences an event that qualifies as a Special Enrollment event under the provisions of HIPAA or an event that allows the Covered Person to change their election under a Section 125 (or “cafeteria”) plan. See “Pre-Tax Premium Payment” below for additional information.

SPECIAL ENROLLMENT RIGHTS. If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health insurance or group health plan coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan if the Employee or his Dependents lose eligibility for that other coverage (or if an employer stops contributing towards the Employee’s or his Dependent’s other coverage), provided that the Employee requests enrollment within 31 days after the other coverage ends (or within 31 days after an employer stops contributing towards the other coverage). In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

SPECIAL ENROLLMENT PERIOD. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan upon the occurrence of one of the following:

- 1) the Employee or Dependent loses other health coverage and meets the following conditions:
 - a) the individual had other health coverage at the time he became eligible for the Plan;
 - b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
 - c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or incurring a claim that would meet or exceed a lifetime limit on all benefits under the other coverage), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will not trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
 - d) the individual makes a request for enrollment under the Plan within 31 days after losing the other coverage.

If an Employee fails to provide the written statement required under b) above, the Plan may not provide special enrollment to the Employee or any of his Dependents.

- 2) the Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request for enrollment under the Plan within 31 days of such event.
- 3) the Employee or Dependent loses coverage under Medicaid or Children’s Health Insurance Coverage (CHIP) due to loss of eligibility for Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of the loss of coverage.
- 4) the Employee or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, and makes a request for enrollment under the Plan within 60 days of such event.

EFFECTIVE DATE FOR EMPLOYEE COVERAGE. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
 - b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
 - a) the date the Employee becomes eligible for coverage; or
 - b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 31 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE. If an Employee fails to make written application for coverage within 31 days of his initial eligibility under the Plan (or, fails to request enrollment within 31 days of the occurrence of an event which would entitle him to Special Enrollment, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

REHIRED EMPLOYEES. Employees who are terminated from employment and are rehired within 30 days following termination will not be required to satisfy the waiting period. These Employees and their Dependents will also receive credit for any Deductible and Out-of-Pocket which was previously satisfied, as well as for any maximums which may have been all or partially met. Employees who are terminated and rehired more than 30 days after their termination date will not receive any type of credit for previous participation in the Plan.

EMPLOYEES ON MILITARY LEAVE. Employees going into or returning from military services will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage. In cases where leave is for more than 31 days, the Employee cannot be required to pay any more than 102 percent of the full premium. If the Employee performs services for less than 31 days, he or she cannot be required to pay more than the normal Employee share for such coverage. Regardless of whether extended health care coverage is elected or declined, the Employee is entitled to immediate coverage under the Plan with no pre-existing condition exclusions applied, upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service. Plan exclusions and waiting periods may be imposed for an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

ELIGIBILITY FOR DEPENDENT COVERAGE. An Employee becomes eligible for Dependent Coverage on the later of:

- 1) the date the Employee becomes eligible for coverage; or
- 2) the date the Employee first acquires a Dependent.

EFFECTIVE DATE FOR DEPENDENT COVERAGE. Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:

- 1) for a Special Enrollment:
 - a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested;
 - b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested;
 - c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator, provided that special enrollment is timely requested; and
- 2) for all other enrollments, the date which is the later of:
 - a) the date the Employee becomes eligible for Dependent coverage; or
 - b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 31 days of the eligibility date.

DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE. If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

NEWBORNS. A newborn child will become covered from moment of birth. If the Employee does not have Dependent coverage in force, this coverage will end 31 days after the date the child is born. If the Employee enrolls the child within 31 days and makes the required retroactive contributions, coverage on the newborn may continue. A newborn child is covered separately and must meet his or her own Deductible and Out-of-Pocket Maximum.

NO MULTIPLE STATUS. You may not have multiple status under the Plan (*i.e.*, you may not receive benefits under this Plan as both an Employee and as a Dependent).

PRE-TAX PREMIUM PAYMENT. Your portion of your health care premium will be paid with pre-tax dollars. With this feature, your portion of the premium for the coverage(s) you have elected is subtracted from your gross pay before taxes are determined. By doing this, your taxable pay is reduced so you pay less in taxes. Once you have made your elections for coverage for yourself and your Dependents, you cannot change them during the **Plan Year** unless you experience a change in status such as:

- 1) marriage or divorce;
- 2) birth or adoption of a child, change in child custody, or the addition of stepchildren;
- 3) death of a Dependent;
- 4) a child reaching the disqualifying age for coverage;
- 5) any significant change in health care coverage for the Employee or the Employee's spouse due to the spouse's employment;
- 6) commencement of employment by the Employee's spouse;
- 7) the Employee or the Employee's spouse switching from part-time to full-time employment or vice versa;
- 8) the beginning or end of the Employee's spouse's employer-provided insurance coverage because of a change in employment status; or
- 9) a change in the Employee's employment status that affects benefit eligibility.

Any change in your coverage election under the Plan must be consistent with the change in status.

WHEN COVERAGE ENDS

EMPLOYEE COVERAGE. An Employee's coverage will terminate on the earliest of:

- 1) the date this Plan is terminated;
- 2) the end of the period for which the last required Employee contribution for the Employee's coverage has been paid;
- 3) the last day of the calendar month in which the covered Employee ceases to be in a class eligible for coverage under the Plan; or
- 4) the last day of the calendar month in which the covered Employee's employment with the County terminates.

Ceasing active work is deemed termination of employment unless:

- 1) cessation of work is due to an approved leave of absence other than FMLA. In that event, coverage may be continued up to 12 months during the disability provided required Employee contributions, if any, are made by such covered Employee; or
- 2) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective.

A covered Employee's coverage for any specific benefit will terminate on the earlier of:

- 1) the date coverage under the Plan for such benefit ends; or
- 2) the date the covered Employee ceases to be eligible for that benefit.

Coverage under this Plan will be terminated immediately upon finding that Covered Person has committed, participated in, or is participating in the commission of, fraud against the Plan. Fraud against the Plan includes, but is not limited to:

- 1) a Covered Person furnishing or participating in furnishing fraudulent information to the Plan for the purpose of obtaining benefits under the Plan (i.e., false health-related treatment claims);
- 2) permitting improper use of his or her identification card;
- 3) use of another Covered Person's Plan identification card; or
- 4) prescription forgery, falsification, or transfer of medication.

DEPENDENT COVERAGE. Dependent coverage will cease for any Dependent on the earliest of:

- 1) the date the covered Employee's coverage terminates;
- 2) the date this Plan is terminated;
- 3) the date Dependent coverage is discontinued under this Plan;
- 4) the last day of the calendar month in which the covered Employee ceases to be in a class eligible for Dependent coverage;
- 5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;
- 6) the date the covered Employee no longer has any Dependents;
- 7) the date the individual ceases to qualify as a Dependent under this Plan; or
- 8) the date the Dependent becomes covered as an Employee under the Plan.

RETIRED EMPLOYEES. If a covered Employee is age 55 or older and has worked for Wayne County Commissioners for a minimum of 25 years, such Employee and eligible Dependents (if the Employee had Dependent coverage prior to retirement) may continue coverage under this Plan during such retirement. When the Retiree or eligible Dependent becomes Medicare eligible this Plan will become secondary.

In the event the Retired Employee dies, the spouse and Dependents will continue coverage until the earliest of:

- 1) the date any required contribution for coverage fails to be made;
- 2) the date a surviving spouse remarries;
- 3) the date the Plan is terminated;
- 4) the date the Dependent ceases to qualify as an eligible Dependent; or
- 5) the date the Dependent becomes eligible for other group coverage.

LIMITED CONTINUATION OF COVERAGE. As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan in certain limited circumstances. A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:

- 1) the covered Employee's employment is terminated (for reasons other than gross misconduct); or
- 2) the covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.

The 18 months of continuation coverage may be extended in two situations: (1) if a Covered Person is determined to be disabled, or (2) another event occurs which would cause a covered Employee's covered Dependent to lose coverage, provided certain notices are timely provided to the Plan Administrator. See the paragraphs below titled "Notice: Disability Extension" and "Notice: Second Qualifying Events."

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:

- 1) the covered Employee dies;
- 2) the covered Employee is divorced or legally separated;
- 3) the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- 4) a child covered under the Plan ceases to be a Dependent.

Notwithstanding the foregoing:

- If the covered Employee has a nonforfeitable right to a benefit any portion of which is to be paid by the Pension Benefit Guarantee Corporation as of the date of his or her termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued until the covered Employee's death, or, in the case of his or her covered Dependents, for 24 months after the covered Employee's date of death; provided, in no event will coverage be continued under this provision later than December 31, 2010, or any later date as required under applicable law.

- If a covered Employee is a TAA-eligible individual as of the date his continuation coverage would otherwise terminate, coverage may be continued until the date the covered Employee ceases to be a TAA-eligible individual; provided, however, that in no event will coverage be continued under this provision beyond December 31, 2010, or any later date as required under applicable law.

NOTICE: GENERAL. Covered Person's Responsibility. A Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. A Covered Person must give this notice prior to the qualifying event or as soon as possible thereafter, and not later than 60 days after the qualifying event occurs. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator.

The "COBRA Notification Form" must be sent, along with applicable documentation indicated on the form (such as a divorce decree, separation order, death certificate, birth certificate, or other documentation verifying a Dependent child's age), to the Plan Administrator at the address listed under "PLAN INFORMATION." When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

If a Covered Person fails to provide the Plan Administrator with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived. A Covered Person who elects COBRA coverage will have the same annual enrollment rights that apply to active employees.

County's Responsibility. For other qualifying events (a covered Employee's end of employment or reduction of hours of employment, death of a covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)), the County will notify the Plan Administrator. When the Plan Administrator receives this notice, it or its designee will notify the applicable Covered Persons (individually or jointly) of the right to elect COBRA coverage.

NOTICE: DISABILITY EXTENSION. If a Covered Person is Totally Disabled under the Social Security definition at the time of a reduction in hours or termination of employment, or becomes disabled within 60 days of beginning COBRA coverage, all Covered Persons with respect to the disabled individual may extend the continuation coverage period an additional 11 months for up to a total of 29 months.

To extend coverage beyond the 18-month period, a Covered Person must notify the Plan Administrator of the Social Security Administration's ("SSA's") determination within 60 days after the later of: (1) the date of the SSA's determination, or (2) the date on which the qualifying event occurs under this Plan, and in all cases before the end of the 18-month period of COBRA coverage. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and must be sent, along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed under "PLAN INFORMATION."

If a Covered Person is determined by the SSA to no longer be disabled, the Covered Person must notify the Plan Administrator of that fact within 30 days of the SSA's determination. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator, and which must be sent along with a copy of the SSA's disability determination, to the Plan Administrator at the address listed under "PLAN INFORMATION."

Upon receipt of this notice, COBRA coverage extended beyond the maximum that would otherwise apply will be terminated on the first day of the month which is 30 days after the determination that the Covered Person is no longer disabled.

NOTICE: SECOND QUALIFYING EVENTS. If a covered Dependent experiences another qualifying event while already on COBRA coverage due to the covered Employee's employment termination or reduction in hours, the covered Dependent may elect to extend the period of COBRA coverage for up to 36 months from the date of the employment termination or reduction in hours. For example, assume that the covered Employee and his covered Dependents elect COBRA coverage because of the covered Employee's employment termination.

If the covered Employee dies during the first 18 months of COBRA coverage, the covered Dependents could elect to continue COBRA coverage for up to 36 months from the covered Employee's date of employment termination.

A Covered Person must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. This notice must be provided on the "COBRA Notification Form," which can be obtained from the Plan Administrator and must be sent, along with applicable documentation, to the Plan Administrator at the address listed under "PLAN INFORMATION."

ELECTION. A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage. If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. If a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will begin on the date the waiver is revoked. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person who is certified as eligible for Trade Adjustment Assistance ("TAA") elects continuation coverage during the second election period described below, continuation coverage will begin on the first day of the second election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

However, if a Covered Person fails to make an election during the 60-day election period, and is certified as TAA-eligible under the Trade Act of 2002, the TAA-eligible Covered Person may elect continuation coverage during the 60-day period that begins on the first day of the month in which the individual is certified to be eligible for TAA benefits, but only if the election is made no later than six months after the date of the TAA-related loss of coverage under the Plan (the “second election period”).

COST OF CONTINUATION COVERAGE. To receive continuation coverage, the Covered Person, or any third party, must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is eligible for an extension of coverage due to disability, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (“PBGC”) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the health Coverage Tax Credit Customer contact center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

BENEFITS UNDER CONTINUATION COVERAGE. If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated Employees, their spouses, and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

PAYMENT OF CLAIMS. No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

TERMINATION. A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

- 1) the date on which the County ceases to provide a group health plan to any Employee;
- 2) the date the Covered Person first becomes covered under any other group health plan after electing continuation coverage, provided that applicable law precludes any pre-existing condition exclusion in the new plan from affecting the Covered Person's coverage under the new plan;
- 3) the date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
- 4) the date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
- 5) the end of the applicable continuation coverage period described above.

When Coverage Ends

In no case will coverage extend beyond 36 months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.

ELIGIBLE CHARGES

BENEFITS. After a Covered Person has satisfied any applicable Deductible, eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any eligible charge will generally be equal to the percentage of the lesser of the billed amount, the Reasonable Charge, Customary Charge, or the PPO allowance as described in “MEDICAL BENEFITS.”

MAXIMUM BENEFITS. The benefits paid for a Covered Person's Illnesses and Injuries will not exceed the maximum for a Covered Person shown in “MEDICAL BENEFITS.” Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the lesser of the billed amounts, the Reasonable Charges or Customary Charges, or the PPO allowances, when charges are incurred for an Illness or Injury for one or more of the following:

- 1) Room and Board and routine nursing services for each day of confinement in a Hospital;
- 2) Intensive or cardiac care Room and Board if Medically Necessary;
- 3) Medical services and supplies furnished by a Hospital;
- 4) Anesthetics and their administration by a Physician (see “DEFINITIONS”);
- 5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures. When two or more Surgical Procedures occur during the same operative session, the eligible expense for all charges is the lesser of the billed amount, Reasonable Charge, Customary Charge, or PPO allowance for:
 - a) 100% for the first or major procedure; 50% for the second procedure; 25% for the third procedure; 10% for the fourth procedure; 5% for the fifth procedure; and over five procedures will be on a special consideration basis;
 - b) bilateral procedures which add significant time or complexity, will be allowed at 100% for the major procedure and 50% for the secondary or lesser procedure; and
 - c) charges made for services rendered by an assistant surgeon will be allowed at 25% for the primary surgeon;
- 6) Charges for non-physician assistants at surgery, if the assistant is certified by his or her professional association, licensed with the state where employed, is credentialed by the facility to assist with the procedure, and is performing a service that would otherwise be performed by a Physician, and is performing a procedure which, according to the National Correct Coding Initiative allows an assistant at surgery;
- 7) Services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for outpatient private duty nursing;
- 8) Occupational Therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Illness or Injury and improve a body function;
- 9) Physical Therapy by a licensed physical therapist. Therapy must be ordered by a Physician or surgeon as to type, duration and frequency, but only to the extent that the therapy is for improvement of bodily function;
- 10) Speech Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either surgery for correction of a congenital condition of oral cavity, throat, or nasal complex (other than a frenectomy) of a person, an Injury, or an Illness;
- 11) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae;

- 12) X-rays, laboratory tests, and other diagnostic services which:
 - a) are performed as a result of definite symptoms of an Illness or Injury; or
 - b) reveal the need for medical treatment;
- 13) X-ray and radiation therapy, chemotherapy, and renal/peritoneal dialysis;
- 14) The transport of a Covered Person:
 - a) within the continental United States and Canada;
 - b) by means of a professional land or air ambulance service;
 - c) to a Hospital for a Medical Emergency, but not returning from a Hospital;
- 15) Medical supplies as follows:
 - a) drugs and medicines (including diabetic supplies):
 - i) which are approved by the Food and Drug Administration;
 - ii) which require the written prescription of a Physician;
 - iii) which must be dispensed by a currently licensed pharmacist or Physician; and
 - iv) which are purchased through the "PRESCRIPTION DRUG PROGRAM;"
 - b) blood and blood derivatives that are not donated or replaced, marrow, or other fluids;
 - c) artificial limbs and eyes to replace natural limbs and eyes;
 - d) repair and adjustment of prosthetic devices, when Medically Necessary;
 - e) contact lenses or lenses for standard glasses only if required promptly after, and because of, cataract surgery;
 - f) casts, splints, trusses, braces, crutches, and surgical dressings;
 - g) rental or purchase, if less expensive, of Hospital-type equipment including, but not limited to wheelchairs, Hospital beds, and oxygen equipment; and
 - h) purchase of a wig after chemotherapy and/or radiation;

Charges for services performed in an Outpatient Surgical Center or Birthing Center;
- 16) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
 - a) follows a Hospital confinement for which at least three straight days of Hospital Room and Board charges were included as eligible charges under the Plan;
 - b) begins within 14 days after the Covered Person is released from such Hospital confinement;
 - c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and
 - d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;
- 17) Second Surgical Opinion;
- 18) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 31 days of his birth. Routine newborn care includes:
 - a) Hospital charges for Room and Board, services, and supplies;
 - b) charges related to circumcision; and
 - c) fees from Physicians for routine Inpatient pediatric care;
- 19) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
 - a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;

- b) care received from an interdisciplinary team of professionals for Hospice and home care; and
 - c) post-bereavement counseling during the six months following the death of the terminally ill patient;
- 20) Home Health Care provided by a Home Health Care Provider if:
- a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care Provider;
 - b) the Covered Person is Totally Disabled and is essentially confined to the home;
 - c) the Covered Person would otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility;
 - d) the Covered Person is examined by the attending Physician at least once every 60 days; and
 - e) the plan of treatment including Home Health Care is:
 - i) established in writing by the attending Physician prior to the commencement of such treatment; and
 - ii) certified by the attending Physician at least once every month;
- Eligible Home Health Care services will not include:
- a) custodial care;
 - b) meals or nutritional services;
 - c) housekeeper services;
 - d) services or supplies not specified in the Home Health Care plan;
 - e) services of a relative of the Covered Person;
 - f) services of any social worker;
 - g) transportation services;
 - h) care for tuberculosis;
 - i) care for Substance Abuse/Substance Dependence;
 - j) care for the deaf or blind; or
 - k) care for senility, mental deficiency, retardation or mental illness;
- 21) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
- a) reconstruction of the breast on which the mastectomy has been performed;
 - b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and
 - c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;
- 22) Services related to organ transplants when the Covered Person is the recipient (including charges for the organ procurement to the extent that they are not covered by the donor's insurance coverage) for the following procedures:
- a) cornea; d) pancreas; g) heart/lung;
 - b) heart; e) liver; h) bone marrow; and
 - c) lung; f) kidney; i) kidney/pancreas;
- 23) Charges for Accidental Injury to or care of mouth, teeth, gums, and alveolar processes, but only if that care is for:
- a) treatment of an Accidental Injury to Sound Natural Teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in an Accident, if received within 12 months after such Accident;

- b) excision of tumors, cysts, and growths of the jaws, cheeks, lips, tongue, roof and floor of the mouth; and
- c) osseous surgery;
- 24) Surgical treatment of diseases, Injuries, fractures, and dislocations of the jaw;
- 25) Charges for tubal ligation and vasectomy;
- 26) Charges for treatment, services, and/or supplies for a Mental or Nervous Disorder, Substance Abuse, or Substance Dependence;
- 27) Routine services as outlined in “MEDICAL BENEFITS;” and
- 28) Bariatric surgery will be covered if the Covered Person meets the following criteria:
 - a) the Body Mass Index (BMI), defined as [weight (kilograms)/height² (meters²)] is utilized to determine if a patient meets the category classification of morbid obesity. The highest mortality has been shown in the individuals with a BMI of 45kg/m² or greater. As a general rule, therefore, a BMI of 40 kg/m² or greater should be utilized as the criteria to define the morbidly obese patient and should be used as the prerequisite for approval for bariatric surgery. A patient with a BMI of between 35-39 kg/m² and documented complications of obesity such as severe hypertension, sleep apnea syndrome, congestive heart failure, or poorly controlled diabetes mellitus should be considered an exception;
 - b) morbid obesity as defined in number a) should have been present for a 3-5 year interval;
 - c) has at least one of the following:
 - i) a health problem or strong family history of a health problem, which is related to obesity and which may ultimately become life threatening. These health problems include severe hypertension, difficult to manage hypertension, sleep apnea syndrome, congestive heart failure, or poorly controlled diabetes mellitus;
 - ii) a serious incapacity caused by the obesity (such as the inability to work, or inability to perform the normal activities of daily living);
 - iii) psychosocial discrimination related to the morbid obesity as documented by psychiatric evaluation; or
 - iv) psychiatric dysfunction related to morbid obesity again documented by a psychiatric evaluation;
 - d) six consecutive months of documented unsuccessful effort to lose weight in a structured weight loss program with dietary consultation and supervision;
 - e) pre-morbid conditions, which may contribute to the obesity, must have been evaluated and an attempt made to treat such conditions must have been made and documented. A minimal time frame for such treatment must be at least 12 months. Conditions that should be evaluated and treated prior to surgery include diabetes mellitus, hypothyroidism, other endocrinopathies, eating disorders, obsessive-compulsive disorder, depression, and personality disorders;
 - f) the patient should be absent of any other existing medical conditions that would cause the risk/benefit ratio of bariatric surgery to increase to an unsafe level of severity for the patient to be considered a reasonable candidate to undergo the Surgical Procedure. These medical conditions might include congestive heart failure (CHF), hypertensive cardiovascular disease (HCVD), coronary artery disease (CAD), adult onset of diabetes mellitus (AODM), Pickwickian syndrome, chronic renal insufficiency (CRI), pulmonary hypertension, and chronic obstructive pulmonary disease (COPD);

Eligible Charges

- g) the Covered Person should be without evidence of gastrointestinal, hepatic or renal disease contraindications to bariatric surgery;
- h) the Covered Person must demonstrate the absence of existing medical problems too severe to be a reasonable candidate to undergo bariatric surgery;
- i) the Covered Person must be between 16 and 60 years of age; and
- j) prior to approval for and undergoing bariatric surgery, the Covered Person must have a documented and planned post-surgery medical management plan supervised by a Physician specializing in the management of patient's status post bariatric surgery.

EXCLUSIONS AND LIMITATIONS

ABORTION. No benefits will be paid for any abortion for a Dependent child, or for any abortion which is not Medically Necessary to preserve the life of a mother unless a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion.

ACUPUNCTURE. No benefits will be paid for needle puncture or application of pressure at specific points whether used to cure disease, to relieve pain, or as a form of anesthesia for surgery.

BIRTH CONTROL. No benefits will be paid for contraceptives (oral, injection, devices, implants, etc.) under the medical Plan.

BREAST SURGERY. No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in "ELIGIBLE CHARGES." Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.

COMPLICATIONS OF NON-COVERED TREATMENT. Except for breast surgery as outlined above, no benefits will be paid for care, services, or treatment required as a result of complications from a treatment not covered under this Plan.

COSMETIC TREATMENT. No benefits will be paid for Cosmetic Treatment, except for that which:

- 1) results from an Illness or Injury; or
- 2) is indicated because of congenital birth defects.

COURT MANDATED. No benefits will be paid for services that are provided due to a court order, except as required by federal law.

CUSTODIAL CARE. No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.

DRUGS - POISON. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Illness or Injury to Covered Persons over the age of seven, which is due to:

- 1) the voluntary and intentional taking of drugs except those taken as prescribed by a Physician;
- 2) the voluntary and intentional taking of poison; or
- 3) the voluntary and intentional inhaling of gas.

However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

DURABLE MEDICAL EQUIPMENT. No benefits will be paid for the purchase of Durable Medical Equipment or supplies which remain with the Provider following the Covered Person's use thereof.

EDUCATIONAL/RECREATIONAL/BIOFEEDBACK. No benefits will be paid for any services or supplies deemed to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training.

EXPERIMENTAL/INVESTIGATIONAL. Benefits will not be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational:

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

Reliable evidence shall mean:

- a) only published reports and articles in the authoritative medical and scientific literature;
- b) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
- c) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

FOOT CARE LIMITATION. No benefits will be paid for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.

GOVERNMENT AGENCIES. No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.

HAIR LOSS. No benefits will be paid for drugs prescribed to eliminate baldness, hair transplants, or for the purchase of artificial hairpieces, except as outlined in "ELIGIBLE CHARGES."

HAZARDOUS ACTIVITY. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any condition, illness, injury, or complication thereof, arising out of engaging in a hazardous activity, which is an unusual activity characterized by a constant threat of danger, such as but not limited to skydiving, auto racing, hang gliding, and bungee jumping. This does not include common recreational activities, such as water or snow skiing, jet ski operating, horseback riding, boating, motorcycling, snowmobiling, all-terrain vehicle riding, and team sports. However, this exclusion shall not apply to injuries resulting from an act of domestic violence or a medical condition (physical or mental).

HEARING AIDS. No benefits will be paid for examinations to determine the need for, or for the fitting or purchase of hearing aids.

HYPNOSIS. No benefits will be paid for hypnotherapy treatment.

ILLEGAL ACTIVITY. No benefits will be paid for any illness or injury which is incurred while taking part in an illegal activity, including but not limited to felonies, misdemeanors, or an attempt to commit a crime, regardless of whether the Covered Person is charged with, or convicted of, such activity.

INFERTILITY. No benefits will be paid for the treatment of infertility, artificial insemination, in vitro fertilization, or other attempts to induce pregnancy, including drug therapy.

LEARNING/BEHAVIOR DISORDERS. No benefits will be paid for special education, treatment, or training for learning or behavior disorders.

LEGAL DUTY. Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay. No coverage will be provided for any services, supplies, or treatment (1) for which the Covered Person is not legally required to pay, (2) for which no charge would usually be made, (3) for which a charge if made would not usually be collected if no coverage existed, or (4) to the extent the charge for services, supplies, or treatment exceeds the charge that would have been made and collected if no coverage existed.

MATERNITY EXPENSES. No benefits will be paid for pregnancy expenses for a dependent child, including pre-natal, delivery and post-natal care, treatment of miscarriage, and complications due to pregnancy.

MEDICALLY NECESSARY. No benefits will be paid for charges which are not medically necessary.

NO CHARGE. No benefits will be paid for care and treatment for which there would not have been a charge if no coverage had been in force.

NON-MEDICAL CHARGES. No benefits will be paid for sales tax, interest, charges made for completion of claim forms or for providing supplemental information, or expenses incurred for failure to keep a scheduled appointment.

NUTRITIONAL SUPPLEMENTS. No benefits will be paid for vitamins, minerals, and food supplements whether or not prescribed by a Physician.

ORTHOPEDIC SHOES. No benefits will be paid for orthopedic shoes (or other supportive devices for the feet), unless they are an integral part of a leg brace and the cost is included in the Physician's charge.

OTHER. Benefits will not be paid for charges not listed under "ELIGIBLE CHARGES."

OUTSIDE THE UNITED STATES. No benefits will be paid for charges incurred outside the United States if the Covered Person traveled to such location for the sole purpose of obtaining those services, drugs, and supplies that are unavailable or illegal in the United States.

PERSONAL COMFORT ITEMS. No benefits will be paid for personal comfort items or other equipment such as, but not limited to air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription medications, first-aid supplies, and non-hospital adjustable beds.

PHYSICIAN'S DIRECT CARE. Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.

PRE-EXISTING CONDITIONS. If charges are incurred as a result of an Illness or Injury which the Plan Administrator finds to be pre-existing, payment for such charges will be limited in accordance with "PRE-EXISTING CONDITIONS."

PRESCRIPTIONS/MEDICATIONS. No benefits will be paid for any prescriptions or medications which are excluded under the "PRESCRIPTION DRUG PROGRAM."

REASONABLE AND CUSTOMARY. No benefits will be paid for charges which are more than the Reasonable Charge or Customary Charge.

RELATIVE PERFORMING SERVICE. No benefits will be paid for charges for the services of a Physician or any other Provider of services:

- 1) who usually resides in the same household with the Covered Person; or
- 2) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.

REVERSAL OF STERILIZATION. No benefits will be paid for the reversal of sterilization.

RIOT – CIVIL DISTURBANCE. No benefits will be paid for any Illness or Injury which is incurred while taking part in a riot or civil disturbance.

SELF-INFLICTED. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

SERVICES BEFORE OR AFTER COVERAGE. No benefits will be paid for care, treatment, or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

SEXUAL DYSFUNCTION. No benefits will be paid for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

TEMPOROMANDIBULAR JOINT DISORDER. No benefits will be paid for the diagnosis and treatment of, or in connection with, temporomandibular joint disorders, myofascial pain dysfunction, or orthognathic treatment.

TREATMENT OF TEETH AND GUMS. Except as described in “ELIGIBLE CHARGES,” no benefits will be paid for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.

VISION CARE. No benefits will be paid for:

- 1) treatment of refractive errors including, but not limited to, routine eye examinations, eye glasses or contact lenses or the fitting of them, eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
- 2) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.

This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.

WAR. No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.

WEIGHT CONTROL. No benefits will be paid for the treatment of, or services or supplies related to, obesity, weight control, or diet, including but not limited to surgery, treatment of complications or adverse reactions to any prior surgery, nutritional counseling, food products, and medications. Bariatric surgery intended to correct Morbid Obesity is covered if considered Medically Necessary to preserve the life and health of the Covered Person and all of the conditions listed in “ELIGIBLE CHARGES” are met. However, the treatment plan and surgery must be pre-approved by the Third Party Administrator prior to services being rendered in order to be considered for coverage.

WELL CHILD CARE. No benefits will be paid for routine well baby/child care, except routine newborn care as stated in “ELIGIBLE CHARGES.”

WORK RELATED ILLNESS OR INJURY. No benefits will be provided for an Illness or Injury which arises out of or in the course of employment, regardless of whether workers’ compensation or other similar coverage is available.

PRE-EXISTING CONDITIONS

Except as stated below, this Plan does not pay benefits for "pre-existing conditions." A "pre-existing condition" is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the individual's enrollment date; provided, however, genetic information shall not be treated as a "pre-existing condition" in the absence of a diagnosis of the condition related to such information.

Notwithstanding any other provision of "PRE-EXISTING CONDITIONS" to the contrary, in no event shall a pre-existing condition exclusion apply to the following:

- 1) pregnancy;
- 2) Covered Persons under the age of 19, so long as the Covered Person is enrolled in the Plan within 31 days after birth, adoption, placement for adoption, or a special enrollment event, whichever is applicable, at open enrollment or according to the provisions set forth in "WHEN COVERAGE BEGINS;" and
- 3) prescription drugs purchased through the "PRESCRIPTION DRUG PROGRAM."

For purposes of this pre-existing condition section, "enrollment date" means the first day of coverage under the Plan or, if earlier, the first day of the waiting period under the Plan.

An individual covered under the Plan will be subject to these pre-existing condition limitations for the duration of the pre-existing condition exclusion period. For purposes of this Plan, the "pre-existing condition exclusion period" is the 12-month period (18 months for late enrollees) following the enrollment date, as reduced by any period of "creditable coverage."

For purposes of this section, "creditable coverage" means coverage under any of the following:

- 1) a group health plan;
- 2) health insurance coverage;
- 3) coverage under Medicare;
- 4) coverage under Medicaid (other than coverage consisting solely of the program for distribution of pediatric vaccines);
- 5) medical coverage for members of the uniformed services and their dependents;
- 6) medical care programs of the Indian Health Service or other tribal organizations;
- 7) a state health benefits risk pool;
- 8) the Federal Employees Health Benefits Program;
- 9) a public health plan (as defined in federal regulations);
- 10) health coverage under the Peace Corps Act; and
- 11) health coverage under the State Children's Health Insurance Program.

For purposes of this section, the pre-existing condition exclusion period shall be reduced by the days of creditable coverage, excluding any creditable coverage incurred prior to a "break in coverage."

"Break in coverage" means a period of more than 63 days during which an individual has no type of creditable coverage. A break in coverage will not include any waiting periods under the Plan or any other plan or insurance coverage.

However, if a Covered Person is certified as eligible for Trade Adjustment Assistance, a break in coverage will not include the period between the loss of health coverage and the date COBRA commences under the special COBRA election (see "Cost of Continuation Coverage" under "WHEN COBRA ENDS").

To demonstrate evidence of creditable coverage, individuals must present to the Plan Administrator a Certificate(s) of Group Health Plan Coverage, issued by the prior plan(s) or insurance carrier(s), or, in the absence of such Certificate(s), such other evidence of health coverage as may be required by the Plan Administrator, including but not limited to, copies of claim forms, explanations of benefits, pay stubs reflecting premium payments, and summary plan descriptions. If necessary, the Plan Administrator will assist an individual in obtaining the Certificate(s) of Group Health Plan Coverage.

Upon enrollment in the Plan, each individual will be required to provide evidence of creditable coverage to the Plan Administrator. Upon receipt of the evidence of creditable coverage, the Plan Administrator shall review the evidence and will provide to each individual a notice regarding to what extent any pre-existing condition limitation exclusion shall apply to the individual. The notice will contain the name of the Plan, the period to which the pre-existing condition exclusion applies (including the last day of the pre-existing condition exclusion period), the basis for the determination of the exclusion period (including the source and substance of any information on which the Plan relied), an explanation of the right to submit additional evidence of creditable coverage, and notice of the right to appeal the Plan Administrator's decision. Each individual who receives a determination regarding the imposition of a pre-existing condition exclusion period shall have the right to appeal the determination directly to the Plan Administrator and to present additional evidence of prior creditable coverage. For information on appeals procedures, refer to "FILING A CLAIM."

MANAGED CARE

PRE-CERTIFICATION/CONTINUED STAY REVIEW. Except in certain cases concerning childbirth, a Covered Person must call iPROCERT at least 72 hours prior to Hospital admission for a medical condition, Mental or Nervous Disorder, or Substance Abuse/Substance Dependence treatment, and in case of an emergency hospitalization, must call within two working days following admission. The number for **iPROCERT** is **(800) 319-9416**.

The Covered Person must provide iPROCERT with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by iPROCERT.

The iPROCERT medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan's procedures for pre-admission or continued stay review, the pre-certification penalty described in "MEDICAL BENEFITS" will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

Pre-certification by iPROCERT does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.

MOTHERS AND NEWBORNS. Notwithstanding any other provision of this "MANAGED CARE" section, the Plan shall not:

- 1) restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) a normal vaginal delivery, to less than 48 hours, or (b) a cesarean section, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother; or
- 2) require any Covered Person or Provider to obtain authorization under the pre-certification features of this section in conjunction with any such stay that does not exceed the number of hours set forth in 1) above.

CASE MANAGEMENT PROGRAM. The case management program is a special program designed for Covered Persons who are suffering from a complex Illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

Case management is a voluntary service. There are no reductions of benefits or penalties if the Covered Person chooses not to participate.

ALTERNATIVE CARE. The Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the right to administer this Plan thereafter in strict accordance with its express terms.

COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:

- 1) group, blanket, or individual insurance;
- 2) Hospital or medical service pre-payment plans;
- 3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
- 4) government plans or programs;
- 5) coverage required or provided by law;
- 6) no fault auto insurance, including medical payments coverage ("MPC") and personal injury protection ("PIP");
- 7) third party liability insurance; and
- 8) any other source, including, but not limited to, crime victim restitution funds, any medical, disability, or other benefit payments, and school insurance coverage.

COORDINATION PROCEDURES. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below.

The primary plan pays its benefits first, without taking other plans into consideration. The secondary plan then pays benefits up to the extent of its liability, after taking into consideration the benefits provided by the other plan. Benefits under any other plan include benefits which the Covered Person could have received if such benefits had been claimed.

If the benefits paid by the secondary plan are less than the Plan would have paid as primary, the unused benefits will be set aside as COB savings. COB savings may be used to pay any benefits which are not covered by the normal payments of the primary and secondary plans, as long as the expense is allowable under one of the plans. COB savings is accrued on a **Plan Year** basis and can only be used in the **Plan Year** in which it has accrued.

No more than 100% of allowable expenses will be paid by the combination of this Plan, COB savings and any other plan(s). "Allowable expense" means any eligible charges which are Reasonable Charges, Customary Charges, Medically Necessary, and covered under at least one of the Plans. When this Plan is secondary (i.e., when this Plan pays after another Plan), "allowable expense" will include any Deductible, Coinsurance, or Copay amounts not paid by the other plan. "Allowable expense" will not include any PPO, HMO, or other Provider discounts. An "allowable expense" will not include an expense incurred when coverage is not in effect under this Plan.

- 1) If a plan has no COB provision, it is automatically the primary plan;
- 2) If all the plans have COB provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a Dependent;

- 3) If a person is covered as a Dependent child under more than one plan:
 - a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
 - b) if the father and mother share the same birthday, the Plan covering the parent longer is the primary plan;
 - c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
 - d) if parents are separated or divorced, the following applies:
 - the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;
- 4) If a plan is no fault auto insurance (including MPC and PIP), required by law, or third party liability insurance, it is the primary plan; and
- 5) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS. This Plan will not consider any charges in excess of what an HMO or PPO Provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO Provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.

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

RIGHT TO EXCHANGE DATA. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

PAYMENT AND OVERPAYMENT. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.

GOVERNMENT BENEFITS. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

EFFECT OF MEDICARE ON BENEFITS. A covered Employee who reaches age 65, and his spouse, may remain covered by the Plan unless the Employee or spouse makes an election to waive coverage under this Plan and chooses Medicare as the primary payer of benefits. In the event that an Employee or spouse waives coverage under this Plan and thereby elects Medicare as the primary source of benefits, no benefits will be payable under this Plan. If an Employee or spouse who is entitled to Medicare does not waive coverage under the Plan, Medicare will be the secondary payer of benefits.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease, or as of the date coverage under the Plan is exhausted, whichever occurs first.

MEDICAID COVERAGE. A Covered Person's eligibility for any state Medicaid benefits will not be taken into account by the Plan in determining that Covered Person's benefits under the Plan.

SUBROGATION AND REIMBURSEMENT

WHEN THIS PROVISION APPLIES. You or your Dependent(s) (hereinafter "beneficiary") may incur medical or dental expenses because of Illness or Injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or dental expenses incurred. In these instances, the Plan has no duty or obligation to pay claims related to this Illness or Injury. However, if the Plan chooses to pay benefits, it has both a right of Subrogation and a right of Reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of Subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of Subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of Subrogation or Reimbursement shall be held in trust for the benefit of the Plan. Under this right of Reimbursement, the beneficiary will be required to reimburse the Plan out of any monies the beneficiary receives from the other person or on behalf of the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred. The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of Subrogation and Reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

The beneficiary may be required to execute a Subrogation Reimbursement Agreement and/or a Trust Agreement to receive benefits under the Plan. Failure to execute these documents upon request by the Plan Administrator may result in the non-payment of any related Claims. Further, if the beneficiary fails to return signed copies of these documents within the time period specified by the Plan Administrator, the Plan may refuse to pay Claims incurred with respect to the Illness or Injury from the date of your Injury or Illness through the date the Plan Administrator receives the signed documents. If the documents are received after the deadline established by the Plan Administrator, the Plan will pay eligible Claims incurred subsequent to its receipt of the signed documents.

Notwithstanding the foregoing, even if the Plan chooses not to have the beneficiary execute a Subrogation Reimbursement Agreement or the beneficiary fails to return a signed Subrogation Reimbursement Agreement, and the Plan pays any claims on behalf of the beneficiary and the beneficiary accepts payment of the claims, (1) the Plan will not be considered to have waived its right to pursue Subrogation and/or Reimbursement with respect to any claims it pays on behalf of the beneficiary, (2) the beneficiary will be deemed to have accepted the terms of the Plan, including the Subrogation and Reimbursement provisions described in this section, and (3) the beneficiary will be deemed to agree to maintain any payment received from another party in a constructive trust.

AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or dental benefits paid for the Illness or Injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of Subrogation and Reimbursement. In addition, the beneficiary must notify the Plan Administrator of any action, judgment, settlement or other recovery for which the Plan has rights of Subrogation and Reimbursement. Further, the beneficiary will do nothing to prejudice the right of the Plan to Subrogation or Reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

The beneficiary shall be entitled to recover payment for benefits under the Plan only once. In the event a beneficiary becomes entitled to recovery from the Plan Administrator for a work-related Illness or Injury, and the amount of such recovery includes amounts for medical benefits previously paid by the Plan, the Plan Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by the Plan.

DEFINED TERMS

- 1) **"Recovery"** means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
- 2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and
- 3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

RIGHTS OF RECOVERY. Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a Covered Person or by a representative of a Covered Person, that complies with the Plan's procedure for making benefit Claims.

HOW TO MAKE A CLAIM:

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

- Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.
- Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.
- Step 3) If items 1 and or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.
- Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.
- Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:
 - a) the employer's name, or group number;
 - b) the Employee's name;
 - c) the Employee's social security number;
 - d) the patient's name;
 - e) the Physician's name;
 - f) the type of service rendered;
 - g) an itemization of the charges;
 - h) the condition for which the service was incurred;
 - i) the date of service; and
 - j) Accident/Injury detail, if applicable (can be provided by the Covered Person on a separate document).
- Step 6) Forward all related bills and receipts to the Administrative Service Agent for processing.

Step 7) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

NON-U.S. PROVIDERS. Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States are payable under the Plan, subject to “EXCLUSIONS AND LIMITATIONS”, maximums, and other provisions under the following conditions:

- 1) benefits may not be assigned to a Non-U.S. Provider;
- 2) the Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
- 3) benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
- 4) the Non-U.S. Provider will be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- 5) claims for benefits must be submitted to the Plan in English.

TYPES OF CLAIMS AND TIME PERIOD FOR PROCESSING. There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. A period of time begins at the time the Claim is filed. “Days” means calendar days.

URGENT CARE CLAIM. A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care decision could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of the attending or consulting Physician, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Covered Person has failed to follow the Plan’s procedure for filing a Claim:	
Notification to Covered Person of deficiency, orally or in writing	24 hours
Response by Covered Person, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	48 hours after receipt of additional information or expiration of Covered Person’s time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan’s benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method.

PRE-SERVICE CLAIM. A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see “MANAGED CARE” for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	15 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Notification, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim	5 days
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	15 days
Determination as to extending course of treatment	15 days
Review of adverse benefit determination	30 days

POST-SERVICE CLAIM. A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a claim that is a request for payment under the Plan for covered medical services already received by the Covered Person for which no prior approval was required. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Covered Person of benefit determination (adverse or not)	30 days
Extension due to matters beyond the control of the Plan	15 days
If there is insufficient information on the Claim:	
Notification to Covered Person of deficiency	15 days
Response by Covered Person	At least 45 days
Review of adverse benefit determination	60 days

NOTICE OF ADVERSE BENEFIT DETERMINATIONS. Except with Urgent Care Claims (in which event the notification may be given orally followed by written or electronic notification within three days of the oral notification), the Plan Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

- 1) the specific reason(s) for the adverse determination;
- 2) reference to the specific Plan provision(s) on which the determination was based;
- 3) a description of any additional material or information necessary for the Covered Person to perfect the Claim and an explanation of why such material or information is necessary;
- 4) a description of the Plan's review procedures and the time limits applicable to such procedures, including any expedited review procedures for urgent care Claims, as well as any other statements required under the law; and
- 5) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the Covered Person upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not Medically Necessary or the Experimental/Investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEAL OF ADVERSE BENEFIT DETERMINATION. When a Covered Person receives an adverse benefit determination, the Covered Person has 180 days following receipt of the notification in which to appeal the decision.

Except as otherwise required by law, the right to appeal shall belong solely to the Covered Person seeking benefits, and may not be assigned, transferred or in any way conferred upon any other person or persons. Any such attempted assignment shall be void. Nothing in this Plan Document shall be construed to confer liability on the Plan, the County or the Plan Administrator to any provider or assignee for medical care, treatment or other services provided to a Covered Person in the event of an attempted assignment of a Covered Person's right to appeal an adverse benefit determination.

A Covered Person may submit written comments, documents, records and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by the Covered Person relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

NOTICE OF ADVERSE DETERMINATION ON APPEAL. The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:

- 1) the specific reason(s) for the adverse determination;
- 2) reference to the specific Plan provision(s) upon which the determination was based;
- 3) a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of all document, records, and other information relevant to the Covered Person Claim for benefits; and
- 4) any other information required by law.

In addition, if the determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

QUESTIONS ON CLAIMS CALL:

**GROUP RESOURCES® AT: (800) 749-9963
MONDAY THROUGH FRIDAY, BETWEEN 8:30 AM AND 5:00 PM EST.
OR VISIT OUR WEBSITE AT: www.groupresources.com**

PRE-ADMISSION CERTIFICATION CONTACT:

**iPROCERT AT: (800) 319-9416
THIS SERVICE IS AVAILABLE 24 HOURS A DAY, SEVEN DAYS A WEEK.**

PROOF OF LOSS. A Claim must be made no later than one year from the date of service unless the Covered Person was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

PHYSICAL EXAMINATIONS. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

TIME BAR TO LEGAL ACTION. No legal action may be commenced or maintained against the Plan prior to the Covered Person's exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the Plan more than 90 days after the Plan Administrator's decision on review.

MISCELLANEOUS PLAN PROVISIONS

AMENDMENT OR TERMINATION. The continued maintenance of the Plan is completely voluntary on the part of the County and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the County intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

COMPLIANCE WITH FEDERAL LAWS. The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

- 1) Americans With Disabilities Act of 1990;
- 2) Family and Medical Leave Act of 1993;
- 3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
- 4) Health Insurance Portability and Accountability Act of 1996, as amended;
- 5) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
- 6) The Newborns' and Mothers' Health Protection Act of 1996;
- 7) The Mental Health Parity Act of 1996, as amended;
- 8) The Women's Health and Cancer Rights Act of 1998;
- 9) The U.S. Trade Promotion Authority Act of 2002;
- 10) The Working Families Tax Relief Act of 2004 (H.R.1308);
- 11) The Genetic Information Non-Discrimination Act of 2008;
- 12) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008;
- 13) The American Recovery and Reinvestment Act of 2009, as amended;
- 14) The Children's Health Insurance Program Reauthorization Act of 2009; and
- 15) The Patient Protection and Affordable Care Act of 2010.

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

PATIENT PROTECTION AND AFFORDABLE CARE ACT. This Plan believes it is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ‘Affordable Care Act’). As permitted by the Affordable care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NON-DISCRIMINATION. Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or a Dependent of that individual with respect to health coverage on the basis of a health factor.

Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment in the Plan or coverage in connection with enrollment in the Plan.

SEVERABILITY. If any provision, or any portion thereof, contained in this Plan is held to be unconstitutional, illegal, invalid, or unenforceable, the remainder of this Plan shall not be affected and shall remain in full force and effect.

ASSIGNABILITY. Amounts payable at any time may be used to make direct payments to health care Providers. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

No appeal rights granted to the Covered Person in this Plan may be assigned, transferred, or in any way made over to another party by a Covered Person. Nothing contained in the written description of the medical coverage shall be construed to make the Plan liable to any third-party to whom a Covered Person may be liable for medical care, treatment, or services.

NATIONAL CORRECT CODING INITIATIVE. Where not otherwise specified, this Plan follows National Correct Coding Initiative ("NCCI") for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

PLAN INFORMATION

Name of the Plan: Wayne County Commissioners
Employee Health Benefit Plan

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

Wayne County Commissioners
341 East Walnut Street
Jesup, GA 31546
(912) 427-5900

Employer Identification Number (EIN): 58-6000906

Plan Number: 501

Type of Plan: Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the County. While the County may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan.

Name, address, and telephone number of the Administrative Service Agent:

Group Resources®
3080 Premiere Parkway
Suite 100
Duluth, GA 30097-4904
(770) 623-8383

The designated agent for service of legal process is:

Wayne County Commissioners
341 East Walnut Street
Jesup, GA 31546

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

Wayne County Commissioners
341 East Walnut Street
Jesup, GA 31546

Claims Administration:

The plan is administered by the Plan Administrator, with Group Resources[®], an Administrative Service Agent, acting as Claims paying agent.

Plan Funding:

County and Employee contributions cover the cost of the Plan. County contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the County and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee's paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary.

The Plan fiscal year ends on:

January 31