



# Enloe Medical Center Employee Medical Benefit Plan

## *Summary Plan Description / Benefit Document*

Amended and Restated **JANUARY 2011**

**ENLOE**  
MEDICAL CENTER



### Contract Administrator:

Keenan & Associates  
2355 Crenshaw Boulevard, Suite 300  
Torrance, CA 90501

# TABLE OF CONTENTS

<b>Important Notice From Enloe Medical Center About Your Prescription Drug Coverage and Medicare .....</b>	<b>1</b>
<b>Medicaid &amp; Childrens' Health Insurance Protection Program .....</b>	<b>4</b>
<b>Directory of Service Providers .....</b>	<b>7</b>
<b>Important Notices .....</b>	<b>8</b>
The Newborns' and Mothers' Health Protection Act .....	8
The Women's Health and Cancer Rights Act .....	8
The Mental Health Parity & Addiction Equity Act .....	8
Genetic Information & Non-Discrimination Act .....	8
COBRA Notification Procedures .....	8
Notice of Right to Receive a Certificate of Creditable Coverage .....	9
Health Insurance Portability and Accountability Act (HIPAA) .....	9
Pregnancy Discrimination Act .....	10
Family and Medical Leave Act (FMLA) .....	10
Qualified Medical Child Support Order (QMCSO) .....	10
Uniformed Services Employment and Reemployment Rights Act (USERRA) .....	10
<b>Introduction .....</b>	<b>11</b>
Your ID Card is Your Passport to Health Care Services .....	11
Use of Masculine Pronoun .....	11
Definitions .....	11
Solicitud de Informaciones en Espanol .....	11
Who to Contact for Additional Information .....	11
<b><u>Medical Benefits</u></b>	
<b>Utilization Management Program .....</b>	<b>12</b>
Pre-Service Review Requirements .....	12
Mental Health Care/Substance Use Disorder Care Outpatient Authorization Program .....	13
Case Management Services .....	13
<b>Medical Benefit Summary - Classic Option .....</b>	<b>14</b>
Choice of Providers .....	14
Schedule of Medical Benefits .....	15
<b>Medical Benefit Summary - Value Option .....</b>	<b>19</b>
Limited Choice of Providers .....	19
Schedule of Medical Benefits .....	20
<b>Eligible Medical Expenses .....</b>	<b>24</b>
<b>Medical Limitations and Exclusions .....</b>	<b>30</b>
<b>Special Restrictions for Pre-Existing Conditions .....</b>	<b>33</b>
<b><u>Prescription Benefits</u></b>	
<b>Prior Authorization Requirements .....</b>	<b>34</b>
<b>Drug Quantity Management .....</b>	<b>34</b>
<b>Specialty Drugs .....</b>	<b>34</b>
<b>Step Therapy .....</b>	<b>34</b>

Schedule of Prescription Benefits – Classic Option.....	35
Schedule of Prescription Benefits – Value Option.....	35
Covered Drugs.....	36
Expenses Not Covered.....	36
Filing a Claim When the ID Card Is Not Accepted or Is Not Available.....	37

**General Information**

General Exclusions.....	39
Coordination of Benefits (COB).....	41
Subrogation & Reimbursement Provisions.....	43
Eligibility and Effective Dates.....	46
Termination of Coverage.....	50
Extension(s) of Coverage.....	51
Claims Procedures.....	53
Definitions.....	58
General Plan Information.....	63
Statement of Rights.....	69
COBRA Continuation Coverage.....	71

## FEDERAL HEALTHCARE REFORM NOTICES

### Statement of Belief

#### Grandfather Status

Enloe Medical Center Employee Welfare Benefit Plan believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grand-fathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of an overall lifetime limit on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (530) 332-7344. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

#### Special Enrollment Opportunity for Children Under Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Enloe Medical Center Employee Welfare Benefit Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information contact the Plan Administrator at (530) 332-7344.

#### Overall Lifetime Limit No Longer Applies Special Enrollment Opportunity

The overall lifetime limit on the dollar value of benefit under Enloe Medical Center Employee Welfare Benefit Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the Plan are eligible to enroll in the plan. Individuals have 30 days from the date of notice to request enrollment. For information contact the Plan Administrator at (530) 332-7344.

## **Important Notice from ENLOE MEDICAL CENTER About Your Prescription Drug Coverage and Medicare**

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with ENLOE MEDICAL CENTER and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. ENLOE MEDICAL CENTER has determined that the prescription drug coverage offered by the ENLOE MEDICAL CENTER EMPLOYEE WELFARE BENEFIT PLAN is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

### **What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?**

If you decide to join a Medicare drug plan, your current ENLOE MEDICAL CENTER coverage will not be affected. See pages 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at [http://www.cms.hhs.gov/Creditable\\_Coverage/](http://www.cms.hhs.gov/Creditable_Coverage/)), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D).

If you do decide to join a Medicare drug plan and drop your ENLOE MEDICAL CENTER prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

### **When Will You Pay a Higher Premium (Penalty) To Join A Medicare Drug Plan?**

You should also know that if you drop or lose your current coverage with Enloe Medical Center and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

### **For More Information About This Notice Or Your Current Prescription Drug Coverage...**

Contact customer service for further information at 888-605-1396. NOTE: You'll get this notice each year. You will also get it if this coverage through Enloe Medical Center changes. You also may request a copy of this notice at any time.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

Date:	January, 2011
Name of Entity/Sender:	ENLOE MEDICAL CENTER
Contact:	Express Scripts, Inc. – Customer Service
Address:	PO Box 66583, St. Louis, MO, 63166-6583
Phone Number:	888-605-1396

## **Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families**

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer’s health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility –**

<b>ALABAMA – Medicaid</b>	<b>CALIFORNIA – Medicaid</b>
Website: <a href="http://www.medicaid.alabama.gov">http://www.medicaid.alabama.gov</a> Phone: 1-800-362-1504	Website: <a href="http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx">http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx</a> Phone: 1-866-298-8443
<b>ALASKA – Medicaid</b>	<b>COLORADO – Medicaid and CHIP</b>
Website: <a href="http://health.hss.state.ak.us/dpa/programs/medicaid/">http://health.hss.state.ak.us/dpa/programs/medicaid/</a> Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: <a href="http://www.colorado.gov/">http://www.colorado.gov/</a> Medicaid Phone: 1-800-866-3513 CHIP Website: <a href="http://www.CHPplus.org">http:// www.CHPplus.org</a> CHIP Phone: 303-866-3243
<b>ARIZONA – CHIP</b>	
Website: <a href="http://www.azahcccs.gov/applicants/default.aspx">http://www.azahcccs.gov/applicants/default.aspx</a> Phone: 1-877-764-5437	
<b>ARKANSAS – CHIP</b>	<b>FLORIDA – Medicaid</b>
Website: <a href="http://www.arkidsfirst.com/">http://www.arkidsfirst.com/</a> Phone: 1-888-474-8275	Website: <a href="http://www.fdhc.state.fl.us/Medicaid/index.shtml">http://www.fdhc.state.fl.us/Medicaid/index.shtml</a> Phone: 1-866-762-2237

<b>GEORGIA – Medicaid</b>	<b>MONTANA – Medicaid</b>
Website: <a href="http://dch.georgia.gov/">http://dch.georgia.gov/</a> Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: <a href="http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml">http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml</a> Telephone: 1-800-694-3084
<b>IDAHO – Medicaid and CHIP</b>	<b>NEBRASKA – Medicaid</b>
Medicaid Website: <a href="http://www.accesstohealthinsurance.idaho.gov">www.accesstohealthinsurance.idaho.gov</a> Medicaid Phone: 1-800-926-2588 CHIP Website: <a href="http://www.medicaid.idaho.gov">www.medicaid.idaho.gov</a> CHIP Phone: 1-800-926-2588	Website: <a href="http://www.dhhs.ne.gov/med/medindex.htm">http://www.dhhs.ne.gov/med/medindex.htm</a> Phone: 1-877-255-3092
<b>INDIANA – Medicaid</b>	<b>NEVADA – Medicaid and CHIP</b>
Website: <a href="http://www.in.gov/fssa/2408.htm">http://www.in.gov/fssa/2408.htm</a> Phone: 1-877-438-4479	Medicaid Website: <a href="http://dwss.nv.gov/">http://dwss.nv.gov/</a> Medicaid Phone: 1-800-992-0900 CHIP Website: <a href="http://www.nevadacheckup.nv.org/">http://www.nevadacheckup.nv.org/</a> CHIP Phone: 1-877-543-7669
<b>IOWA – Medicaid</b>	
Website: <a href="http://www.dhs.state.ia.us/hipp/">www.dhs.state.ia.us/hipp/</a> Phone: 1-888-346-9562	<b>NEW HAMPSHIRE – Medicaid</b>
Website: <a href="https://www.khpa.ks.gov">https://www.khpa.ks.gov</a> Phone: 800-766-9012	Website: <a href="http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm">http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm</a> Phone: 1-800-852-3345 x 5254
<b>KENTUCKY – Medicaid</b>	<b>NEW JERSEY – Medicaid and CHIP</b>
Website: <a href="http://chfs.ky.gov/dms/default.htm">http://chfs.ky.gov/dms/default.htm</a> Phone: 1-800-635-2570	Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a> Medicaid Phone: 1-800-356-1561 CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a> CHIP Phone: 1-800-701-0710
<b>LOUISIANA – Medicaid</b>	
Website: <a href="http://www.lahipp.dhh.louisiana.gov">http://www.lahipp.dhh.louisiana.gov</a> Phone: 1-888-342-6207	<b>NEW MEXICO – Medicaid and CHIP</b>
Website: <a href="http://www.maine.gov/dhhs/oms/">http://www.maine.gov/dhhs/oms/</a> Phone: 1-800-321-5557	Medicaid Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Medicaid Phone: 1-888-997-2583 CHIP Website: <a href="http://www.hsd.state.nm.us/mad/index.html">http://www.hsd.state.nm.us/mad/index.html</a> Click on Insure New Mexico CHIP Phone: 1-888-997-2583
<b>MASSACHUSETTS – Medicaid and CHIP</b>	
Medicaid & CHIP Website: <a href="http://www.mass.gov/MassHealth">http://www.mass.gov/MassHealth</a> Medicaid & CHIP Phone: 1-800-462-1120	<b>NEW YORK – Medicaid</b>
Website: <a href="http://www.dhs.state.mn.us/">http://www.dhs.state.mn.us/</a> Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: <a href="http://www.nyhealth.gov/health_care/medicaid/">http://www.nyhealth.gov/health_care/medicaid/</a> Phone: 1-800-541-2831

<b>MISSOURI – Medicaid</b>	<b>NORTH CAROLINA – Medicaid</b>
Website: <a href="http://www.dss.mo.gov/mhd/index.htm">http://www.dss.mo.gov/mhd/index.htm</a> Phone: 573-751-6944	Website: <a href="http://www.nc.gov">http://www.nc.gov</a> Phone: 919-855-4100
<b>NORTH DAKOTA – Medicaid</b>	<b>UTAH – Medicaid</b>
Website: <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a> Phone: 1-800-755-2604	Website: <a href="http://health.utah.gov/medicaid/">http://health.utah.gov/medicaid/</a> Phone: 1-866-435-7414
<b>OKLAHOMA – Medicaid</b>	<b>VERMONT – Medicaid</b>
Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a> Phone: 1-888-365-3742	Website: <a href="http://ovha.vermont.gov/">http://ovha.vermont.gov/</a> Telephone: 1-800-250-8427
<b>OREGON – Medicaid and CHIP</b>	<b>VIRGINIA – Medicaid and CHIP</b>
Medicaid & CHIP Website: <a href="http://www.oregonhealthykids.gov">http://www.oregonhealthykids.gov</a>  Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: <a href="http://www.dmas.virginia.gov/rcp-HIPP.htm">http://www.dmas.virginia.gov/rcp-HIPP.htm</a> Medicaid Phone: 1-800-432-5924 CHIP Website: <a href="http://www.famis.org/">http://www.famis.org/</a> CHIP Phone: 1-866-873-2647
<b>PENNSYLVANIA – Medicaid</b>	<b>WASHINGTON – Medicaid</b>
Website: <a href="http://www.dpw.state.pa.us/partnersproviders/medicalsassistance/doingbusiness/003670053.htm">http://www.dpw.state.pa.us/partnersproviders/medicalsassistance/doingbusiness/003670053.htm</a> Phone: 1-800-644-7730	Website: <a href="http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm">http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm</a> Phone: 1-877-543-7669
<b>RHODE ISLAND – Medicaid</b>	<b>WEST VIRGINIA – Medicaid</b>
Website: <a href="http://www.dhs.ri.gov">www.dhs.ri.gov</a> Phone: 401-462-5300	Website: <a href="http://www.wvrecovery.com/hipp.htm">http://www.wvrecovery.com/hipp.htm</a> Phone: 304-342-1604
<b>SOUTH CAROLINA – Medicaid</b>	<b>WISCONSIN – Medicaid</b>
Website: <a href="http://www.scdhhs.gov">http://www.scdhhs.gov</a> Phone: 1-888-549-0820	Website: <a href="http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm">http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm</a> Phone: 1-800-362-3002
<b>TEXAS – Medicaid</b>	<b>WYOMING – Medicaid</b>
Website: <a href="https://www.gethipptexas.com/">https://www.gethipptexas.com/</a> Phone: 1-800-440-0493	Website: <a href="http://www.health.wyo.gov/healthcarefin/index.html">http://www.health.wyo.gov/healthcarefin/index.html</a> Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)  
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
1-877-267-2323, Ext. 61565

## DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he has a question or needs help.

TYPE OF SERVICE	PROVIDER
<p><b>Plan Sponsor / Plan Administrator</b> Determines and establishes Plan coverage. Interprets the Plan</p>	<p><b>Enloe Medical Center</b> 1531 Esplanade Chico, CA 95926 (530) 332-7344</p>
<p><b>Contract Administrator</b> Handles medical claims and eligibility determinations. Receives COBRA payments. A Plan participant can also obtain additional information about Plan coverage of a specific treatment, procedure, preventive service, etc. from the Contract Administrator. Answers eligibility and claims questions</p>	<p><b>Keenan &amp; Associates</b> 2355 Crenshaw Boulevard, Suite 300 Torrance, CA 90501 Phone: (310) 212-0363 (877) 365-6399 or (877) Enloe99 (Enloe's customer service no.) <a href="http://www.keenan.com/enloe">www.keenan.com/enloe</a></p>
<p><b>Utilization Management</b> Administers the <b>Utilization Management Program</b> (e.g., pre-admission and review requirements).</p>	<p><b>Anthem Blue Cross</b> Phone: (800) 274-7767</p>
<p><b>Network</b> Provides a Network of providers contracted to provide services at discounted rates.</p>	<p><b>Anthem Blue Cross</b> – in California <a href="http://www.anthem.com/ca">www.anthem.com/ca</a> <b>BlueCard</b> – outside of California <a href="http://www.bluecares.com">www.bluecares.com</a></p>
<p><b>Prescription Drug Vendor</b> Provides a Network of participating retail pharmacies and can answer questions about Plan coverage for a specific drug or drug claims. Also handles Rx claims administration</p>	<p><b>Express Scripts, Inc.</b> Phone (888) 605-1396 <a href="http://www.express-scripts.com">www.express-scripts.com</a></p>

## IMPORTANT NOTICES

Certain Federal laws apply to most group health programs. Many of the laws are amendments to the Employee Retirement Income Security Act (ERISA).

The following is an overview of certain Federal laws and their impact. The effect of these laws on the Plan is reflected in the provisions of the Plan. Should there be any conflict between the law and Plan provisions, the law will prevail.

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### THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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### THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Covered Persons must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

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### MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act was enacted to provide for parity in the application of mental health and substance use disorder benefits with medical/surgical benefits. Although there are certain cost and small employer exemptions, in general, a group health plan that provides medical/surgical benefits and benefits for mental health and substance use disorders must offer benefits for mental health and substance use disorders that are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered under a plan.

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### GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-discrimination Act) was enacted on May 21, 2008 and applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

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### COBRA NOTIFICATION PROCEDURES

The following procedures will apply to Plan participants with regard to notifying the Plan of a COBRA-related event.

#### Notice Responsibilities

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in “(a)” has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

### **Notification Procedures**

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification - Notification of the Qualifying Event must be provided to the Employer’s Human Resources office by completing a *Change Form*. Any new addresses should be included on the *Change Form*.

Notification must include the reason for the loss of coverage (such as divorce or other loss of dependent eligibility).

Delivery of Notification - Notification must be received by the Enloe Medical Center Human Resources Department. Upon receipt, Enloe Medical Center will notify the COBRA Administrator (Keenan & Associates).

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor’s General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see “Effect of the Trade Act” in the **COBRA Continuation Coverage** section of the Plan’s Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor’s General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

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## **NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE**

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a “certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

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## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Covered Persons and beneficiaries receive a summary of any change that is a “material reduction in covered services or benefits under a group health plan” within 60 days after the adoption of the modification or change, unless the Plan Administrator provides summaries of modifications or changes at regular intervals of 90 days or less.

**PREGNANCY DISCRIMINATION ACT**

Most Employers must provide coverage for pregnancy-related conditions in the same manner as coverage is provided for illness. This Act applies to pregnancy-related conditions of an Employee or a Covered Dependent spouse of an Employee. This requirement does not apply to pregnancy-related conditions of a child of an Employee.

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**FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)**

If a covered Employee ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103-3, coverage availability will continue under the same terms and conditions, which would have applied, had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

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**QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) –  
OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA)**

OBRA 1993 requires that an eligible Dependent child of an Employee will include a child who is adopted by the Employee or placed with him for adoption prior to age 18 and a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Administrator to be a Qualified Medical Child Support Order (QMCSO). QMCSO will also include a judgment, decree or order issued by a court of “competent jurisdiction” or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA § 609 (a).

Participants may obtain a copy of the QMCSO procedures from the Plan Administrator without charge.

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**UNIFORMED SERVICES EMPLOYMENT  
AND REEMPLOYMENT RIGHTS ACT (USERRA)**

Under certain circumstances, Employees who are serving as reservists in the armed forces of the United States are eligible for continuation of coverage hereunder when they are on leave from employment due to being called to active duty.

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## INTRODUCTION

This Benefit Document/Summary Plan Description describes our employee health care coverages which are effective as of January 1, 2011. **Enloe Medical Center** is pleased to be able to offer this coverage to you and your eligible dependents.

- ◆ Please review the contents of this document carefully.
- ◆ The Plan coverages described herein are self-funded so the Plan's success is dependent upon our wise choice and use of health care services. With costs always on the rise, cost-conscious use of health care services will better assure our ability to continue to offer quality coverage to our valuable employees and their families.
- ◆ The medical coverages of the Plan include a **Utilization Management Program**. To assure you receive the maximum Plan benefits, make certain you read and understand the requirements of this program.
- ◆ The medical coverages of the Plan are part of a medical/vision benefit package. That is, a person enrolling for medical coverage will also be enrolled for the vision coverage provided through Vision Service Plan (VSP).

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### YOUR I.D. CARD IS YOUR PASSPORT TO HEALTH CARE SERVICES

When you need health care, present your I.D. card to your provider. At each visit, you should verify whether or not your provider is a Network Provider.

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### USE OF MASCULINE PRONOUN

A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.

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### DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will give you a better understanding of the benefits and provisions.

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### SOLICITUD DE INFORMACIONES EN ESPAÑOL

(Spanish Language Offer of Assistance)

Este documento está escrito en inglés y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuníquese con los administradores de la Keenan & Associates.

**Ud. también puede llamar a la oficina del administrador del plan de seguro a este teléfono: (877) 365-6399.**

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### WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). No charge will be made for the information. The Contract Administrator for the benefits described in this document is:

**Keenan & Associates**  
**2355 Crenshaw Boulevard, Suite 300**  
**Torrance, CA 90501**  
**(310) 212-0363**  
**(877) 365-6399 or (877) Enloe99 (Enloe's customer service number)**

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# UTILIZATION MANAGEMENT PROGRAM

(Applies to Enrollees in the Classic and Value Options)

Some of the Plan's medical benefits are subject to pre-service review requirements. The purpose of pre-service review is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

## PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The name and phone number of the organization is shown on the Covered Person's coverage identification card.

**Compliance Procedures:** The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Admission - Except as noted, **at least five (5) business days prior** to any non-emergency Inpatient admission to a Covered Provider facility (Hospital, Skilled Nursing Facility, Inpatient mental health/substance abuse facility, etc.), the Covered Person or someone acting on his behalf must contact the Utilization Management Organization (UMO) for authorization. For an emergency admission, the Utilization Management Organization should be contacted within 24 hours or by the end of the first business day following a weekend or holiday admission. If contact is not made prior to discharge, the admitting facility will have to file a "Retrospective Review" request with the Utilization Management Organization.

If, in the opinion of the patient's Physician, it is necessary for the patient to be confined for a longer time than initially authorized, the Physician may request that additional days be authorized by contacting the UMO no later than the last authorized day.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery which does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

Specified Outpatient Services & Supplies - Prior to receipt of the following services, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for authorization:

- Home health care
- Home infusion (IV) therapy
- Potentially cosmetic/investigative services

Transplant Procedures - The Utilization Management Organization must be contacted for authorization prior to the performance of any transplant procedure.

**Penalty for Non-Compliance:** If the above pre-service review requirements are not completed for an Inpatient admission or any of the other services or procedures listed above, a \$500 penalty will be applied before benefits are determined.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductible requirements or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

## MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed **ONLY** to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits hereunder will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered hereunder.

### **MENTAL HEALTH CARE/SUBSTANCE USE DISORDER CARE OUTPATIENT AUTHORIZATION PROGRAM**

Mental Health Care and Substance Use Disorder Care services require authorization for outpatient care that exceeds twelve (12) visits to a provider. It is the responsibility of the provider to obtain authorization for any visits beyond twelve (12).

Authorization may be requested via telephone or faxed treatment plan.

Medical necessity criteria will be used to evaluate the treatment plan and, if authorized, authorization will continue until treatment goals are met or until treatment no longer meets medical necessity guidelines. If it is determined that the requested service does not meet the medical necessity guidelines, the case will be referred to a peer clinical reviewer.

If the provider does not acquire authorization for services beyond the 12<sup>th</sup> visit, claims for those visits will be denied.

### **CASE MANAGEMENT SERVICES**

The Utilization Management Organization provides case management for catastrophically ill or injured Covered Persons who require extensive medical services and who have exceptional or complex needs. Case managers are responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care for Covered Persons who have been accepted into the case management program. To achieve this objective, the case management program works in collaboration with the Covered Person's team of health care professionals to provide feedback, support and assistance during the utilization and case management process.

Once a Covered Person is identified for potential case management, the Covered Person is contacted for program enrollment. The case manager will introduce and describe the program. The Covered Person can ask questions and agree or decline to participate. If the Covered Person declines to participate, a case manager may work with the health care treatment team to monitor progress through the healthcare continuum.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

**NOTE: Case Management is voluntary. There are no reductions of benefits or penalties if the patient chooses not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.**

## MEDICAL BENEFIT SUMMARY – CLASSIC OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the Classic Option. See “Coverage Options” in the **Eligibility and Effective Dates** section for more information.

### CHOICE OF PROVIDERS

A Covered Person enrolled in the Classic Option has three (3) alternatives when obtaining health care services. He can use Enloe Medical Center (or a Joint Venture Provider), or he can select a Network or a Non-Network Provider.

- 1) Enloe Medical Center & Joint Venture Partners** - A Covered Person will generally have the least out-of-pocket expenses when he uses Enloe Medical Center for services and supplies that are available at that facility (e.g., Inpatient care, Outpatient surgery, physical therapy, lab work & X-rays, durable medical equipment, home health care).

Where services are **not available** at Enloe (e.g., mammogram, breast ultrasound, bone mass measurement, MRI, Outpatient CT, and PET/CT), a Covered Person can receive enhanced benefits by using a Joint Venture Partner. The Joint Venture Partners and the services they provide are as follows:

North State Imaging - provides mammography, breast ultrasound and bone mass measurement  
North Valley Advanced Imaging - provides MRI, CT and PET/CT  
Breast Care Center - provides breast biopsies

If a Joint Venture Provider is used for a service that is **not available** at Enloe, then the Joint Venture Provider charges will be paid at the same level as if the services were provided at Enloe Medical Center and the Calendar Year Deductible will not apply.

If a Joint Venture Provider is used for a service that is **available** at Enloe, then the Joint Venture Provider charges will be paid at 80%. With regard to application or non-application of the Calendar Year Deductible, however, a Joint Venture Provider will be treated in the same manner as a Network Provider.

- 2) Network Providers** - A Covered Person can use a provider who is participating in a Network that has been contracted to provide health care services for Plan participants. Because Network providers have agreed to provide services at negotiated rates, a Covered Person's out-of-pocket costs may be reduced because he will not be billed for charges in excess of those rates. Benefit incentives are also included to encourage Covered Persons to use Network providers - see the Schedule of Medical Benefits, page 15.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access the directory(ies) of Network Providers. This information will be provided without charge. The directory(ies) will be available either in hard copy or in electronic format. Since certain covered services and supplies may not be available through the Network(s), a Covered Person should refer to the Network list(s) or directory(ies) to determine if any particular specialty is included.

#### Enhanced Benefits for an Emergency Medical Condition:

- ◆ If a Covered Person is admitted to a non-Enloe Hospital for an Emergency Medical Condition and the Utilization Management Organization requests that the patient be transferred to Enloe Medical Center and such **transfer takes place**, then expenses for the non-Enloe Hospital's emergency room and Inpatient care will be paid at Enloe benefit levels. If such **transfer does not occur**, then the Inpatient days following the request to transfer will be paid at the usual Non-Network benefit levels, subject to the other terms and conditions herein.
- ◆ If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. At that point, the Covered Person must be transferred to Network provider care or Non-Network benefit levels will commence.

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IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

**MEDICAL BENEFIT SUMMARY – CLASSIC OPTION, continued**

Enhanced Benefits for Ancillary Services - If a Covered Person is receiving covered treatment in a Network facility but receives ancillary services from a Non-Network provider in a situation where he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Enhanced Benefit for Unavailable Services - If necessary Hospital services are not available at Enloe Medical Center (or if there is no Physician available at Enloe to provide the level of care needed), any such services that are provided by a Network Hospital will be covered at the Enloe benefit levels.

Out-of-State Providers - For persons who are traveling or who have Dependents outside of California, there is an out-of-state provider Network. A Covered Person should contact the Contract Administrator for the identity of that Network and instructions on how to use it.

**3) Non-Network Providers** - A Covered Person can choose to use a Covered Provider who is not participating in a Network. A Covered Person is responsible for all costs between the amount the Plan pays and the amount billed by a Non-Network provider.

Enhanced Benefits for an Emergency Medical Condition:

- ◆ If a Covered Person is admitted to a non-Enloe Hospital for an Emergency Medical Condition and the Utilization Management Organization requests that the patient be transferred to Enloe Medical Center and such **transfer takes place**, then expenses for the non-Enloe Hospital's emergency room and Inpatient care will be paid at Enloe benefit levels. If such **transfer does not occur**, then the Inpatient days following the request to transfer will be paid at the usual Non-Network benefit levels.
- ◆ If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. At that point, the Covered Person must be transferred to Network provider care or Non-Network benefit levels will commence.

Enhanced Benefits for Ancillary Services - If a Covered Person is receiving covered treatment in a Network facility but receives ancillary services from a Non-Network provider in a situation where he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Enhanced Benefits for Unavailable Specialist - If a Covered Person must use a Non-Network provider for a covered bariatric or other surgical procedure because there is no Network Provider in the required specialty within twenty-five (25) miles of the person's residence, then the charges of the Non-Network surgeon will be covered at the Network benefit levels.

**SCHEDULE OF MEDICAL BENEFITS**

The **percentages** shown in the following schedule reflect the portion of Eligible Expense that the **Plan pays** after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

A **Co-Pay** is an amount a **Covered Person pays**. Co-Pays are usually paid to the provider at the time of service.

<b>MAXIMUM INDIVIDUAL LIFETIME BENEFIT</b>	Unlimited
<b>CALENDAR YEAR DEDUCTIBLES</b>	<b>(The Deductible is waived for Enloe services)</b>
Individual Deductible	\$250
Family Maximum Deductible	\$750

† Calendar Year Deductible does not apply.

**IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.**

**MEDICAL BENEFIT SUMMARY – CLASSIC OPTION, continued**

**Individual Deductible** - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.

**Family Maximum Deductible** - If \$750 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

**Deductible Carry-Over** - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

<b>OUT-OF-POCKET MAXIMUMS</b>	
Individual Out-of-Pocket Maximum	\$1,500
Family Out-of-Pocket Maximum	\$4,500

**Individual Out-of-Pocket Maximum** - Except as noted, a Covered Person will not be required to pay more than \$1,500 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

**Family Out-of-Pocket Maximum** - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than \$4,500 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

**NOTE: The out-of-pocket maximums do not apply to or include:**

- amounts applied or paid to satisfy any Deductible or Co-Pay requirements;
- expenses incurred at a non-Enloe facility for Inpatient care or Outpatient surgery, unless the expenses are for treatment of an Emergency Medical Condition or the service is not available at Enloe;
- expenses incurred at an out-of-state Non-Network Hospital, unless treatment is for an Emergency Medical Condition;
- any ineligible non-covered expenses; or
- **expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.**

<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Ambulance</b>	90%†	80%	80%
<b>Chiropractic Care</b>	N/A	80%	80%
Limited to 12 visits per Calendar Year.			
<b>Diabetic Daycare Self-Management Education</b>	90%†	80%	80%
Limited to 4 day-care days per 24-month period.			
<b>Diagnostic Lab &amp; X-ray, Outpatient (see NOTE)</b>	100%†	80%	80%
NOTE: There can be times when lab/cultures are taken at Enloe and sent to a non-Enloe laboratory for processing. If this occurs and the Covered Person would like the expense to be paid at the Enloe benefit level, the Covered Person must call the Contract Administrator.			
<b>Durable Medical Equipment</b>	90%†	80%	80%
<b>Home Health Care</b>	90%†	80%	80%
Limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist and each 4-hour period of home health aide services will count as 1 visit.			

† Calendar Year Deductible does not apply.

**IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.**

**MEDICAL BENEFIT SUMMARY – CLASSIC OPTION, continued**

<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospice Care</b>			
Inpatient	100%†	80%†	80%†
Outpatient	90%†	80%†	80%†
<b>Hospital Services</b>			
Inpatient Care	100%†	70%	60%
Emergency Room Use:			
for an Emergency Medical Condition	\$30 Co-Pay†	\$30 Co-Pay†	\$30 Co-Pay†
in a non-emergency	\$30 Co-Pay†	70%	60%
Outpatient Surgery Services	100%†	70%	60%
Outpatient Diagnostic X-ray/Lab (see NOTE)	100%†	80%	80%
Other Outpatient Services & Supplies	90%†	70%	60%
Eligible Expense for Inpatient room and board is limited to the Semi-Private Room Charge or the Usual, Customary and Reasonable charge for necessary confinement to an Intensive Care Unit.			
“Outpatient Surgery Services” includes colonoscopies.			
NOTE: If lab/cultures are taken at Enloe and sent to a non-Enloe lab for processing, the Covered Person must call the Contract Administrator if he would like the expense to be paid at the Enloe benefit level.			
<b>Mental Health &amp; Substance Use Disorder Care</b>			
<u>Hospital Services:</u>			
<u>Inpatient Care:</u>			
for mental health conditions	100%†	70%	60%
for substance use disorders	N/A	70%	60%
Emergency Room Use:			
for an Emergency Medical Condition	\$30 Co-Pay†	\$30 Co-Pay†	\$30 Co-Pay†
in a non-emergency	\$30 Co-Pay†	70%	60%
Other Outpatient Services & Supplies, including Partial Hospitalization	90%†	70%	60%
<u>Physician Services:</u>			
Physician & Counselor Visits, Inpatient	N/A	80%	80%
Physician & Counselor Visits, Outpatient	N/A	\$15 Co-Pay†	80%
Other Physician Services	N/A	80%	80%
Mental Health Care and Substance Use Disorder Care are covered same as Sickness. “Covered same as Sickness” means that the Plan’s <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health conditions or covered substance use disorders (see “Mental Health Care / Substance Use Disorder Care” in the <b>Eligible Medical Expenses</b> section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. “Treatment limitations” include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. “Financial requirements” includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. “Covered same as Sickness” also extends to medical management matters (i.e., utilization review program requirements).			
<b>Orthotics</b>	N/A	80%	80%
Benefits for custom foot orthotics are limited to \$500 per Covered Person per year.			
<b>Physician Services</b>			
Inpatient Care	N/A	80%	80%
Office Visits (visit charge only)	N/A	\$15 Co-Pay†	80%
Other Physician Services	N/A	80%	80%

† Calendar Year Deductible does not apply.

**IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.**

**MEDICAL BENEFIT SUMMARY – CLASSIC OPTION, continued**

<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Prescription Drugs</b> , Outpatient	(see section entitled <b>Prescription Benefit Summary</b> )		
<b>Preventive Care</b> Office Visits (visit charge only) Other Preventive Care Services	N/A 90%†	\$15 Co-Pay† 80%†	80% 80%
<p>“Preventive Care” office visits include:</p> <ul style="list-style-type: none"> <li>• periodic well-baby check-ups for a child under age 3;</li> <li>• 1 physical exam each Calendar Year for Covered Persons age 3 and over;</li> <li>• 1 gynecological or pelvic exam per Calendar Year;</li> <li>• 1 male prostate exam each Calendar Year;</li> </ul> <p>Other “Preventive Care” services include:</p> <ul style="list-style-type: none"> <li>• screening colonoscopy for Covered Persons age 45 or over;</li> <li>• routine diagnostic services, including Pap smears, when ordered by a Physician as part of a routine physical;</li> <li>• immunizations;</li> <li>• mammograms when part of a routine physical; and</li> <li>• birth control methods that require Physician management.</li> </ul>			
<b>Skilled Nursing Facility</b>	N/A	80%	80%
Eligible Expenses for room and board are limited to a semi-private room accommodation.			
<b>Smoking Cessation</b> , per visit	N/A	\$15 Co-Pay†	\$15 Co-Pay†
Benefits are limited to \$250 per Lifetime. See the <b>Prescription Benefit Summary</b> for smoking cessation products.			
<b>Substance Use Disorder Care</b>	(see “Mental Health & Substance Use Disorder Care”)		
<b>Therapy Services</b> (physical, occup., speech)	90%†	80%	80%
<b>Urgent Care Facility</b> Visits (visit charge only), per visit Diagnostic Services Other Services	\$15 Co-Pay† (Prompt Care Clinic) 100%† 90%†	\$15 Co-Pay† 80%† 80%†	\$15 Co-Pay† 80% 80%
Physician expenses for reading X-rays at an Urgent Care facility are covered at 80%.			
<b>All Other Eligible Medical Expenses</b>	90%†	80%	80%

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

† Calendar Year Deductible does not apply.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

## MEDICAL BENEFIT SUMMARY – VALUE OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the Value Option. See “Coverage Options” in the **Eligibility and Effective Dates** section for more information.

### LIMITED CHOICE OF PROVIDERS

**IMPORTANT: EXCEPT FOR AN EMERGENCY MEDICAL CONDITION OR FOR OUT-OF-TOWN URGENT CARE, A COVERED PERSON ENROLLED IN THE VALUE OPTION MUST USE ENLOE MEDICAL CENTER WHEN THE NECESSARY SERVICES ARE AVAILABLE AT ENLOE. WHEN NECESSARY CARE IS NOT AVAILABLE AT ENLOE, A COVERED PERSON CAN USE A JOINT VENTURE PROVIDER, OR HE CAN SELECT A NETWORK OR A NON-NETWORK PROVIDER.**

- 1) **Enloe Medical Center & Joint Venture Partners** - A Covered Person will generally have the least out-of-pocket expenses when he uses Enloe Medical Center for services and supplies that are available at that facility (e.g., Inpatient care, Outpatient surgery, physical therapy, lab work & X-rays, durable medical equipment, home health care).

NOTE: Where services are **not available** at Enloe (e.g., mammogram, breast ultrasound, bone mass measurement, MRI, Outpatient CT, and PET/CT), a Covered Person can receive enhanced benefits by using a Joint Venture Partner. The Joint Venture Partners and the services they provide are as follows:

North State Imaging - provides mammography, breast ultrasound and bone mass measurement  
North Valley Advanced Imaging - provides MRI, CT, and PET/CT  
Breast Care Center – provides breast biopsies

If a Joint Venture Provider is used for a service that is **not available** at Enloe, then the Joint Venture Provider charges will be paid at will be paid at the same coinsurance as Enloe Medical Center and the Calendar Year Deductible will not apply.

If a Joint Venture Provider is used for a service that is **available** at Enloe, then the Joint Venture Provider expenses are not covered.

- 2) **Network Providers** - A Covered Person can use a provider who is participating in a Network that has been contracted to provide health care services for Plan participants. Because Network providers have agreed to provide services at negotiated rates, a Covered Person’s out-of-pocket costs may be reduced because he will not be billed for charges in excess of those rates. Benefit incentives are also included to encourage Covered Persons to use Network providers - see the Schedule of Medical Benefits, page 20.

The Plan Sponsor will automatically provide a Covered Person with information about how he can access the directory(ies) of Network Providers. This information will be provided without charge. The directory(ies) will be available either in hard copy or in electronic format. Since certain covered services and supplies may not be available through the Network(s), a Covered Person should refer to the Network list(s) or directory(ies) to determine if any particular specialty is included.

#### Enhanced Benefits for an Emergency Medical Condition:

- ♦ If a Covered Person is admitted to a non-Enloe Hospital for an Emergency Medical Condition and the Utilization Management Organization requests that the patient be transferred to Enloe Medical Center and such **transfer takes place**, then expenses for the non-Enloe Hospital’s emergency room and Inpatient care will be paid at Enloe benefit levels. However, if such **transfer does not occur**, then Inpatient days following the request to transfer will be paid at the usual Network benefit levels. If the required notification is made and the Utilization Management Organization does not request that the patient be transferred to Enloe Medical Center, then the patient’s Network Hospital charges will be paid at Enloe benefit levels.

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IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

## MEDICAL BENEFIT SUMMARY – VALUE OPTION, continued

- ◆ If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. At that point, the Covered Person must be transferred to Network provider care or Non-Network benefit levels will commence.

Enhanced Benefits for Ancillary Services - If a Covered Person is receiving covered treatment in a Network facility but receives ancillary services from a Non-Network provider in a situation where he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Enhanced Benefit for Unavailable Services - If necessary Hospital services are not available at Enloe Medical Center (or if there is no Physician available at Enloe to provide the level of care needed), any such services that are provided by a Network Hospital will be covered at the Enloe benefit levels.

Out-of-State Providers - For persons who are traveling or who have Dependents outside of California, there is an out-of-state provider Network. A Covered Person should contact the Contract Administrator for the identity of that Network and instructions on how to use it.

- 3) **Non-Network Providers** - In some instances, a Covered Person can choose to use a Covered Provider who is not participating in a Network. A Covered Person is responsible for all costs between the amount the Plan pays and the amount billed by a Non-Network provider. However, non-Enloe Hospital services are not covered unless treatment is for an Emergency Medical Condition or when necessary services are not available at Enloe.

Enhanced Benefits for an Emergency Medical Condition:

- ◆ If a Covered Person is admitted to a non-Enloe Hospital for an Emergency Medical Condition and the Utilization Management Organization requests that the patient be transferred to Enloe Medical Center and such **transfer takes place**, then charges for the non-Enloe Hospital's emergency room and Inpatient care will be paid at Enloe benefit levels. If such **transfer does not occur**, then the Inpatient days following the request to transfer will be paid at the usual Non-Network benefit levels.
- ◆ If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network provider care. At that point, the Covered Person must be transferred to Network provider care or Non-Network benefit levels will commence.

Enhanced Benefits for Ancillary Services - If a Covered Person is receiving covered treatment in a Network facility but receives ancillary services from a Non-Network provider in a situation where he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Enhanced Benefits for Unavailable Specialist - If a Covered Person must use a Non-Network provider for a covered bariatric or other surgical procedure because there is no Network Provider in the required specialty within twenty-five (25) miles of the person's residence, then the charges of the Non-Network surgeon will be covered at the Network benefit levels.

## SCHEDULE OF MEDICAL BENEFITS

The **percentages** shown in the following schedule reflect the portion of Eligible Expense that the **Plan pays** after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the **Definitions** section for more information.

A **Co-Pay** is an amount a **Covered Person pays**. Co-Pays are usually paid to the provider at the time of service.

† Calendar Year Deductible does not apply.

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IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

**MEDICAL BENEFIT SUMMARY – VALUE OPTION, continued**

<b>MAXIMUM INDIVIDUAL LIFETIME BENEFIT</b>	Unlimited		
<b>CALENDAR YEAR DEDUCTIBLES</b>	<b>(The Deductible is waived for Enloe services)</b>		
Individual Deductible	\$250		
Family Maximum Deductible	\$750		
<p><u>Individual Deductible</u> - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.</p> <p><u>Family Maximum Deductible</u> - If \$750 in eligible medical expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p> <p><u>Deductible Carry-Over</u> - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.</p>			
<b>OUT-OF-POCKET MAXIMUMS</b>			
Individual Out-of-Pocket Maximum	\$2,000		
Family Out-of-Pocket Maximum	\$6,000		
<p><u>Individual Out-of-Pocket Maximum</u> - Except as noted, a Covered Person will not be required to pay more than \$2,000 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p><u>Family Out-of-Pocket Maximum</u> - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than \$6,000 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.</p> <p><b>NOTE: The out-of-pocket maximums do not apply to or include:</b></p> <ul style="list-style-type: none"> <li>• amounts applied or paid to satisfy any Deductible or Co-Pay requirements;</li> <li>• expenses incurred at a non-Enloe facility for Inpatient care or Outpatient surgery, unless the expenses are for treatment of an Emergency Medical Condition or the service is not available at Enloe;</li> <li>• expenses incurred at an out-of-state Non-Network Hospital, unless treatment is for an Emergency Medical Condition;</li> <li>• any ineligible non-covered expenses; or</li> <li>• expenses that become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.</li> </ul>			
<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Ambulance</b>	90%†	80%	80%
<b>Chiropractic Care</b>	N/A	Not Covered	Not Covered
<b>Diabetic Daycare Self-Management Education</b>	90%†	Not Covered	Not Covered
Limited to 4 day-care days per 24-month period.			
<b>Diagnostic Lab &amp; X-ray, Outpatient (see NOTE)</b>	100%†	Not Covered	Not Covered
NOTE: There can be times when lab/cultures are taken at Enloe and sent to a non-Enloe laboratory for processing. If this occurs and the Covered Person would like the expense to be paid at the Enloe benefit level, the Covered Person must call the Contract Administrator.			
<b>Durable Medical Equipment</b>	90%†	Not Covered	Not Covered
<b>Home Health Care</b>	90%†	Not Covered	Not Covered
Limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist and each 4-hour period of home health aide services will count as 1 visit.			

† Calendar Year Deductible does not apply.

**IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.**

**MEDICAL BENEFIT SUMMARY – VALUE OPTION, continued**

<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Hospice Care</b> - Inpatient or Outpatient	90%†	Not Covered	Not Covered
<b>Hospital Services</b> Inpatient Care	90%†	90%† (benefits are allowed ONLY in limited instances - see NOTE 1)	90%† (benefits are allowed ONLY in limited instances - see NOTE 1)
Emergency Room Use: for an Emergency Medical Condition in a non-emergency	\$50 Co-Pay† \$50 Co-Pay†	\$50 Co-Pay† 60%	\$50 Co-Pay† 60%
Outpatient Surgery Services	90%†	Not Covered	Not Covered
Outpatient Diagnostic X-ray/Lab (see NOTE 2)	100%†	80%	80%
Other Outpatient Services & Supplies	90%†	Not Covered	Not Covered
Eligible Expense for Inpatient room and board is limited to the Semi-Private Room Charge or the Usual, Customary and Reasonable charge for necessary confinement to an Intensive Care Unit.			
“Outpatient Surgery Services” includes colonoscopies.			
NOTE 1: Non-Enloe Hospital services are covered only for an Emergency Medical Condition or when the necessary services are not available at Enloe.			
NOTE 2: If lab/cultures are taken at Enloe and sent to a non-Enloe lab for processing, the Covered Person must call the Contract Administrator if he would like the expense to be paid at the Enloe benefit level.			
<b>Mental Health &amp; Substance Use Disorder Care</b> <u>Hospital Services:</u> Inpatient Care	90%† (note that substance use disorder care is not available at Enloe)	90%† (benefits are allowed ONLY in limited instances - see NOTE 1 above)	90%† (benefits are allowed ONLY in limited instances - see NOTE 1 above)
Emergency Room Use: for an Emergency Medical Condition in a non-emergency	\$50 Co-Pay† \$50 Co-Pay†	\$50 Co-Pay† 60%	\$50 Co-Pay† 60%
Other Outpatient Services & Supplies, including Partial Hospitalization	90%†	Not Covered	Not Covered
<u>Physician Services:</u> Physician & Counselor Visits, Inpatient	N/A	80%	80%
Physician & Counselor Visits, Outpatient	N/A	\$20 Co-Pay†	80%
Mental Health Care and Substance Use Disorder Care are covered same as Sickness. “Covered same as Sickness” means that the Plan’s <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health conditions or covered substance use disorders (see “Mental Health Care / Substance Use Disorder Care” in the <b>Eligible Medical Expenses</b> section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. “Treatment limitations” include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. “Financial requirements” includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. “Covered same as Sickness” also extends to medical management matters (i.e., utilization review program requirements).			
<b>Orthotics</b>	N/A	80%	80%
Benefits for custom foot orthotics are limited to \$500 per Covered Person per year.			

† Calendar Year Deductible does not apply.

**IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE UTILIZATION MANAGEMENT PROGRAM SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS FOR MORE INFORMATION.**

**MEDICAL BENEFIT SUMMARY – VALUE OPTION, continued**

<b>ELIGIBLE MEDICAL EXPENSES</b>	<b>Enloe</b>	<b>Network Provider</b>	<b>Non-Network Provider</b>
<b>Physician Services</b>			
Inpatient Care	N/A	80%	80%
Office Visits (visit charge only)	N/A	\$20 Co-Pay†	80%
Other Physician Services	N/A	80%	80%
<b>Prescription Drugs, Outpatient</b>	(see section entitled <b>Prescription Benefit Summary</b> )		
<b>Preventive Care</b>			
Office Visits (visit charge only)	N/A	\$20 Co-Pay†	80%
Other Preventive Care Services	90%†	80%†	80%
<p>“Preventive Care” office visits include:</p> <ul style="list-style-type: none"> <li>• periodic well-baby check-ups for a child under age 3;</li> <li>• 1 physical exam each Calendar Year for Covered Persons age 3 and over;</li> <li>• 1 gynecological or pelvic exam per Calendar Year;</li> <li>• 1 male prostate exam each Calendar Year;</li> </ul> <p>Other “Preventive Care” services include:</p> <ul style="list-style-type: none"> <li>• screening colonoscopy for Covered Persons age 45 or over;</li> <li>• routine diagnostic services, including Pap smears, when ordered by a Physician as part of a routine physical;</li> <li>• immunizations;</li> <li>• mammograms when part of a routine physical; and</li> <li>• birth control methods that require Physician management.</li> </ul>			
<b>Skilled Nursing Facility</b>	N/A	80%	80%
Eligible Expenses for room and board are limited to a semi-private room accommodation.			
<b>Smoking Cessation</b> , per visit	N/A	\$20 Co-Pay†	\$20 Co-Pay†
Benefits are limited to \$250 per Lifetime. See the <b>Prescription Benefit Summary</b> for smoking cessation products.			
<b>Substance Use Disorder Care</b>	(see “Mental Health & Substance Use Disorder Care”)		
<b>Therapy Services</b> (physical, occup., speech)	90%†	Not Covered	Not Covered
<b>Urgent Care Facility</b>			
Visits (visit charge only), per visit	\$20 Co-Pay† (Prompt Care Clinic)	\$20 Co-Pay† (only if outside of Chico)	\$20 Co-Pay† (only if outside of Chico)
Diagnostic Services	100%†	80%†	80%
Other Services	90%†	80%†	80%
Physician charges for reading X-rays at an Urgent Care facility are covered at 80%.			
NOTE: Lab and radiology services obtained at a non-Enloe facility will only be covered by the Plan if services were urgent in nature.			
<b>All Other Eligible Medical Expenses</b>	90%†	Not Covered	Not Covered

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

† Calendar Year Deductible does not apply.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION. ALSO, BENEFITS MAY BE REDUCED OR DENIED FOR PREEXISTING CONDITIONS. SEE **SPECIAL RESTRICTIONS FOR PREEXISTING CONDITIONS** FOR MORE INFORMATION.

## ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of Deductible requirements and Coinsurance percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person - subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes medical expenses will be deemed to be incurred on:

- ◆ the date a purchase is contracted;
- ◆ the actual date a service is rendered.

**Abortion:** see "Pregnancy Care"

**Alcoholism:** see "Mental Health & Substance Use Disorder Care"

**Allergy Testing & Treatment:** Allergy testing and treatment, including allergy injections.

**Ambulance, Etc.:** Professional ground and air ambulance service when used to transport the Covered Person from the place where he incurred an Emergency Medical Condition to the nearest Hospital where treatment can be given, including surface transportation required after hospital admission as requested by the Utilization Management Organization (see "Enhanced Benefits for an Emergency Medical Condition" in the **Medical Benefit Summary**).

Charges made by a city or county rescue squad, paramedic or other fire department assistance for responding to an emergency call necessitated by an Accidental Injury or Sickness, whether or not such services include transport of the Covered Person to any type of medical facility.

**Ambulatory Surgical Center:** Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

**Amniocentesis:** see "Pregnancy Care"

**Anesthesia:** Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

**Attention Deficit Disorders (ADD & ADHD):** Testing and treatment (i.e., periodic Physician check-ups for evaluation and medication management) for attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

**Birthing Center:** Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

**Blood:** Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

**Chemical Dependency:** see "Mental Health & Substance Use Disorder Care"

**Chemotherapy:** The use of chemical agents in the treatment or control of disease.

High-dose chemotherapy in connection with a covered transplant procedure. See "Transplant-Related Expenses" (page 29) for additional information.

**Chiropractic Care (Classic Option enrollees only):** Services of a Chiropractor (D.C.). Such services must be rendered in the Covered Provider's office and must be intended to improve a patient's musculoskeletal, neuromuscular and respiratory systems. Covered services include but are not limited to:

- ◆ physical medicine evaluations and management;
- ◆ office visits, manipulations and adjustments;

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IMPORTANT: Certain eligible medical expenses are subject to benefit limits. See the **Medical Benefit Summary** for that information.

- ◆ patient training and treatment utilizing physical agents such as ultrasound, heat and massage; and
- ◆ maintenance care.

**Contraceptives:** Physician-administered contraceptives. See "Preventive Care" in the **Medical Benefit Summary** (*Classic Option* page 18 & *Value Option* page 23).

Any contraceptive that can be obtained from a pharmacy must be obtained in that manner. See the **Prescription Benefit Summary**.

NOTE: Contraceptives that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies, etc.) are not covered. Contraceptive drugs and devices not approved by the FDA are not covered.

**Diabetes Education** - Charges of a diabetic day care center or services of a Physician or other professionals who are knowledgeable about the treatment of diabetes (such as a registered nurse, registered pharmacist or registered dietitian) for the purpose of enabling a diabetic and his family to understand and practice daily management of diabetes.

**Diagnostic Lab & X-ray, Outpatient:** Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

**Dialysis Services:** Dialysis services, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

**Durable Medical Equipment:** Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury. Excess charges for deluxe equipment or devices will not be covered.

Replacement of purchased equipment will be eligible if it is shown that replacement is needed due to a change in the person's physical condition. In other instances, the Plan will determine whether replacement of equipment will be covered. The Plan will determine if expenses for repair of equipment will be eligible.

"Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Routine maintenance of durable medical equipment is not covered. Routine maintenance is responsibility of the Covered Person.

**Genetic Testing / Amniocentesis, Etc.:** see "Pregnancy Care"

**Home Health Care:** Services and supplies which are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must be established in writing by the Covered Person's attending Physician and must be monitored by the Physician during the period of home health care. Also, the attending Physician must certify the condition would require Inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of home health care.

Home health care services and/or supplies must be provided through a Home Health Care Agency or by other Covered Providers as specified in the written home health care plan. Covered home health care services and supplies include, but are not limited to, the following:

- ◆ part-time or intermittent services of a registered nurse (RN) or a licensed vocational nurse (LVN);
- ◆ services of physical, occupational and speech therapists or audiologists;
- ◆ services of licensed clinical social workers;
- ◆ part-time or intermittent services of home health aides under the supervision of a registered nurse (RN) or a physical, occupational or speech therapist;
- ◆ medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had been confined in a Hospital or Skilled Nursing Facility.

NOTE: Covered home health care expenses will not include food, food supplements, home-delivered meals, transportation, housekeeping services or other services which are custodial in nature and could be rendered by non-professionals.

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IMPORTANT: Certain eligible medical expenses are subject to benefit limits. See the **Medical Benefit Summary** for that information.

**Hospice Care:** Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice program charges for:

- ◆ Inpatient Hospice facility services and supplies;
- ◆ professional and other services and supplies including, but not limited to: (1) nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse, (2) physical therapy and speech therapy when rendered by licensed therapists, (3) medical supplies, including drugs and biologicals and the use of medical appliances, (4) Physician services, and (5) services, supplies and treatments deemed Medically Necessary and ordered by a Physician.

Covered services and supplies also include:

- ◆ bereavement counseling sessions for covered family members; and
- ◆ respite care (i.e., professional care to provide family members temporary relief from caring for the patient).

**Hospital Services:** Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

**Infusion Therapy:** Administration, by an appropriate Covered Provider, of prescription drugs by injection into a vein, a muscle, the skin or the spinal canal. It also includes drugs administered by aerosol into the lungs or by a feeding tube.

**Medical Supplies:** Medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

**Medicines:** Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit or as part of a home health care or hospice care program. See **Prescription Benefit Summary** for Outpatient prescription coverage information (page 34).

**Mental Health & Substance Use Disorder Care:** Inpatient and Outpatient treatment of covered mental health conditions and covered substance use disorders.

Mental Health Conditions: For Plan purposes, "mental health conditions" include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, bipolar disorder), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence.

NOTE: A mental health condition or covered mental health care will not include:

- ◆ treatment of learning disabilities, behavioral problems, or mental retardation;
- ◆ hypnotherapy;
- ◆ marriage and family counseling;
- ◆ sex counseling or sex therapy;
- ◆ vocational testing or training;
- ◆ psychological evaluation or testing, or testing for intelligence or learning disabilities;
- ◆ telephone psychiatric consultations.

In no instance will mental health care coverage include confinement in a residential care facility.

Substance Use Disorders: For Plan purposes, a "substance use disorder" is physical and/or emotional dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

NOTE: In no instance will substance use disorder coverage include confinement in a residential care facility.

**Midwife:** Services of a certified or registered nurse midwife if: (1) the nurse midwife is licensed, (2) there is a referring Physician, and (3) the baby is born in a Hospital. See "Pregnancy Care" below.

**Newborn Care:** Inpatient or Outpatient treatment of a newborn who is sick or injured.

Hospital nursery services provided during the birth confinement to a well newborn child.

See also "Newborn & Adoptive Children – Limited Automatic 31-Day Benefit Period" in the **Eligibility and Effective Dates** section.

**Occupational Therapy:** see "Physical Medicine"

**Orthotics:** The following devices when provided to support weak or ineffective joints or muscles:

- ◆ orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and are custom made; and
- ◆ custom foot orthotics that are fitted and provided by a Physician or Podiatrist (DPM). For enrollees in the Classic Option only, a Chiropractor may fit and provide custom foot orthotics.

**Orthognathic Surgery:** see "TMJ / Jaw Treatment"

**Outside United States:** see the **General Exclusions** section for limited instances when out-of-US care will be covered

**Oxygen:** see "Durable Medical Equipment"

**Physical Medicine:** Services of a Physician (MD), registered physical therapist, or a certified occupational therapist, pursuant to a written treatment plan which offers a reasonable expectation of significant improvement. Such services must be rendered in the Covered Provider's office or in the Outpatient department of a Hospital and must be intended to improve a patient's musculoskeletal, neuromuscular and respiratory systems. Covered services include but are not limited to:

- ◆ physical medicine evaluations and management;
- ◆ office visits, manipulations and adjustments;
- ◆ patient training and treatment utilizing physical agents such as ultrasound, heat and massage.

**Physician Services:** Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second Surgical Opinion" below for requirements applicable to surgery opinion consultations.

**Pregnancy Care:** Eligible Pregnancy-related expenses of a Covered Person. Eligible Expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

- ◆ pre-natal visits and routine pre-natal and post-partum care;
- ◆ prenatal diagnosis of genetic disorders of the fetus in the case of a high-risk Pregnancy;
- ◆ expenses associated with a normal or cesarean delivery;
- ◆ genetic testing or amniocentesis when performed on a Covered Person over the age of 35 or when deemed Medically Necessary by a Physician;
- ◆ an elective or non-elective abortion procedure and any complications arising out of an abortion.

**Prescription Drugs:** Drugs and medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit.

Coverage for other Outpatient drugs (i.e., pharmacy purchases) is described in the **Prescription Benefit Summary**. See page 34.

**Preventive Care:** Certain "preventive" measures provided in the absence of sickness or injury. See the **Medical Benefit Summary** for further information (*Classic Option* page 18 & *Value Option* page 23).

**Prosthetics:** Artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.

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IMPORTANT: Certain eligible medical expenses are subject to benefit limits. See the **Medical Benefit Summary** for that information.

NOTE: Prosthetics coverage does not include:

- ◆ dental prosthetics;
- ◆ external penile devices or penile implant devices, except when surgery or devices are Medically Necessary for complications resulting from a covered reconstructive surgery;
- ◆ voice enhancers, voice prosthetics or any other language assistance devices;
- ◆ replacement of a prosthetic device except when Medically Necessary, such as when necessitated by the normal growth processes of a child or due to a change in the Covered Person's physical condition which makes the original device no longer functional; or
- ◆ expenses for repair of a prosthetic.

**Radiation Therapy:** Radium and radioactive isotope therapy.

**Respiratory Therapy:** Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent the therapy is for improvement of respiratory function.

**Second Surgical Opinion:** A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

**Skilled Nursing Facility:** Inpatient care in Skilled Nursing Facility, but only when the admission to the facility is Medically Necessary and is ordered by a Physician in lieu of Hospital confinement.

**Smoking Cessation:** Physician office visits for smoking cessation purposes. See the **Prescription Benefit Summary** (page 34) for coverage information on prescription smoking cessation products.

**Speech Therapy:** Outpatient services of a qualified speech therapist pursuant to a written treatment plan which offers a reasonable expectation of significant improvement. Such services must be provided on referral by a Physician to restore or rehabilitate a speech loss or impairment caused by Accidental Injury or Sickness, including cerebral palsy, but not a mental, emotional or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery, speech therapy is covered only if provided after surgery for the defect.

NOTE: Speech therapy is not covered for the correction of stammering, stuttering, lispings, tongue thrust, speech impediments caused by functional nervous disorders, or developmental speech delays.

**Sterilization Procedures:** A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

**Substance Use Disorder Care:** See "Mental Health & Substance Use Disorder Care"

**TMJ / Jaw Treatment:** Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of temporomandibular joint syndrome (TMJ), and surgical and arthroscopic treatment of TMJ if prior history shows that conservative medical treatment has failed.

Orthognathic surgery (surgery to reposition the upper and/or lower jaw) when Medically Necessary to correct a skeletal deformity.

NOTE: Coverage for TMJ or orthognathic surgery does not include orthodontia services provided for any reason, including any such treatment to alleviate TMJ.

**Transplant-Related Expenses (Human Tissue):** The following transplant procedures for a Covered Person who is the transplant recipient:

- cornea transplants
- kidney transplants
- skin transplants

The following procedures if the recipient is a Covered Person and the transplant is authorized by the Utilization Management Organization and is performed at a transplant facility that is under contract with the Plan to provide the procedure:

- bone marrow. Autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy is covered only in certain circumstances. See NOTE 1, below.
- heart
- heart and lung
- kidney and pancreas
- liver
- lung
- pediatric small bowel
- small bowel and liver

In addition to other Eligible Expenses as listed in this section, eligible transplant-related expenses will include services incident to obtaining the human organ transplant material from a living donor or an organ transplant bank. Any such expenses will be covered as expenses of the transplant recipient.

NOTE 1: Autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy is covered only for:

- Leukemia, lymphoma and Hodgkin's disease in 1<sup>st</sup> or 2<sup>nd</sup> remission
- Neuroblastoma in 1<sup>st</sup> or 2<sup>nd</sup> remission without evidence of marrow involvement
- Glioblastoma when neurologically intact
- Multiple myeloma
- Testicular germ cell carcinoma that has progressed after conventional salvage chemotherapy

NOTE 2: Transplants not specifically mentioned above are not covered.

**Urgent Care Facility:** Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

# MEDICAL LIMITATIONS AND EXCLUSIONS

**Except as specifically stated otherwise, no benefits will be payable for:**

**Acupuncture / Acupressure:** 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.

**Air Purification Units, Etc.:** Air conditioners, air-purification units, humidifiers and electric heating units.

**Biofeedback:** Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

**Cosmetic & Reconstructive Surgery, Etc.:** Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly or complications resulting from any such treatment, except for:

- ◆ reconstructive surgery to repair or alleviate bodily damage caused by an Accidental Injury or Sickness;
- ◆ services provided to comply with the requirements of the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient.

**Custodial & Maintenance Care:** Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

**Dental & Oral Care:** Care or treatment on or to the teeth, gums or alveolar processes, except for:

- ◆ professional services of a Physician, dentist or oral surgeon for the following:
  - initial treatment of damage to sound natural teeth caused by an Accidental Injury;
  - reduction of fractures of the jaw or facial bones;
  - surgical correction of harelip, cleft palate, or protruding or receding mandible;
  - removal of stones from salivary ducts;
  - removal of bony cysts of the jaw, torus palatinus, leukoplakia or malignant tissues; and
  - freeing of muscle attachments; and
- ◆ facility services and supplies, including general anesthesia, when provided in connection with a dental procedure where Hospital confinement or use of the Outpatient services of a Hospital or Ambulatory Surgical Center is required because of an underlying medical condition or clinical status of a Covered Person who: (1) is under the age of seven years, (2) is developmentally disabled, regardless of age, or (3) has impaired health and general anesthesia is Medically Necessary.

See also "TMJ / Jaw Treatment" in the list of **Eligible Medical Expenses** (page 28).

**Diagnostic & Chronic Pain Hospital Admissions:** Confinement in a Hospital that is for: (1) medical observation, or (2) diagnostic purposes and such services could be performed in an Outpatient setting.

Expenses incurred for or incident to hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except for those services which would have been provided had the individual been treated on an Outpatient basis. For example, charges for room and board during a confinement are not covered.

**Ecological or Environmental Medicine:** Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Confinement in a hospital or health care facility primarily to control or change a patient's environment, such as confinement in an eating disorder unit.

## **MEDICAL LIMITATIONS AND EXCLUSIONS, continued**

**Educational or Vocational Testing or Training:** Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

**Exercise Equipment / Health Clubs:** Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

**Foot Care, Routine:** Non-surgical treatment of calluses or toenails, any type of massage procedure on the foot or other routine foot care (e.g., treatment for weak or fallen arches, flat or pronated feet, foot pain or cramp) unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Orthopedic shoes (except when permanently attached to braces) and other supportive appliances for the feet except as specifically outlined under "Orthotics" in the **Eligible Medical Expenses** section, page 27.

**Genetic Counseling or Testing:** Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary during the course of a covered Pregnancy.

**Hair Restoration:** Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

**Hearing Aids, Etc.:** Hearing aids, cochlear implants, or other internal or external devices for the purpose of improving, restoring or stimulating hearing.

**Holistic or Homeopathic Medicine:** Services, supplies, drugs or accommodations provided in connection with holistic or homeopathic treatment.

**Hypnotherapy:** Treatment by hypnotism.

**Impregnation:** Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

**Infertility Testing or Treatment:** Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

**Learning & Behavioral Disorders:** Except as noted, testing or treatment for learning or behavioral disorders.

NOTE: See "Attention Deficit Disorders (ADD & ADHD)" in the list of **Eligible Medical Expenses** for coverage information (page 24).

**Maintenance Care:** see "Custodial & Maintenance Care"

**Marriage & Family Counseling:** Counseling for marital or family problems when there is no diagnosed mental health condition.

### **Massage Therapy**

**Non-Prescription Drugs:** Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter - except as may be included in the prescription coverages (see the **Prescription Benefit Summary**, page 34).

Drugs for which there is a non-prescription equivalent available.

**Not Medically Necessary / Not Physician Prescribed:** Any services or supplies which are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein.

**Nursing Services, Private Duty:** Private duty nursing services. See "Home Health Care" (page 25) and "Hospice Care" (page 26) in the list of **Eligible Medical Expenses** for nursing coverage information.

**Obesity:** see "Weight Control"

**Personal Comfort or Convenience Items:** Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

**Pre-Existing Conditions:** see section entitled **Special Restrictions for Pre-Existing Conditions** for information (page 33)

**Preventive or Routine Care:** Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **Medical Benefit Summary**.

**Residential Care Facility:** Confinement, for any reason, in a residential care facility. A "residential care facility" is a non-medical facility that is primarily engaged in providing assistance with activities of daily living for sick, injured, aged, mentally ill or other persons who have some limits on their ability for self-care, but where medical care is not a major element.

**Self-Procured Services:** Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

**Sex-Related Disorders:** Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

NOTE: This exclusion will not apply to Medically Necessary treatment of medical complications resulting from or incident to a transsexual operation.

**Speech-Related Disorders:** Speech therapy or other services or supplies for the correction of stammering, stuttering, lisping, tongue thrust, speech impediments caused by functional nervous disorders, or development speech delays.

**Sterilization Reversal:** Reconstruction (reversal) of a prior elective sterilization procedure.

**Vision Care:** Eye examinations for the purpose of prescribing corrective lenses, eye glasses or contact lenses or the fitting thereof, vision supplies or their fitting, replacement, repair or adjustment, orthoptics, vision therapy, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy. (Enloe Medical Center vision benefits are administered by VSP)

NOTE: This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery.

**Vitamins or Dietary Supplements:** Non-prescription organic substances used for nutritional purposes.

**Vocational Testing or Training:** Vocational testing, evaluation, counseling or training.

**Weight Control:** Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of morbid obesity. "Morbid obesity" means the Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as the Covered Person.

Surgery for removal of excess fat in any area of the body or resection of any excess skin or fat following weight loss or pregnancy.

**Wigs or Wig Maintenance:** Purchase of a wig or hair piece for cosmetic or hair loss purposes, whether or not hair loss is the result of Sickness or medical treatment (such as chemotherapy), or the repair, replacement or maintenance (cleaning, etc.) of a wig.

- (See also **General Exclusions** section) -

# SPECIAL RESTRICTIONS FOR PRE-EXISTING CONDITIONS

(THIS PROVISION APPLIES TO INDIVIDUALS AGE 19 AND OLDER)

## Definition of a Pre-Existing Condition

For Plan purposes, a "pre-existing condition" is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months before an individual's enrollment date. A Pregnancy will not be considered a pre-existing condition, regardless of the date of conception, diagnosis, or first treatment. Genetic information is not a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

For purposes of the Plan and the above paragraph, the following definitions will apply:

- ◆ medical advice, diagnosis, care or treatment must have been received from a health care provider or practitioner duly licensed to provide such care under state law and who is operating within the scope of practice authorized by applicable state law.
- ◆ "treatment" includes receiving services or supplies, consultations, diagnostic tests or taking drugs or medicines. "Treatment" must be recommended by or received from a Physician.
- ◆ an individual's "enrollment date" is his first day of coverage hereunder or, if there is a waiting period for coverage, the first day of such waiting period. For a late enrollee or an individual enrolling during a special enrollment period, the "enrollment date" is the individual's first day of coverage.

## Special Waiting Periods for a Pre-Existing Condition

A pre-existing condition will not be covered until the 6-month anniversary of: (1) an Employee's date of hire in or transfer to a benefit eligible status, or (2) a Dependent's date of eligibility.

The pre-existing condition waiting periods may be credited if an individual had prior coverage. See "Allowance for Prior Creditable Coverage" below.

## Allowance for Prior Creditable Coverage

An individual (Employee or Dependent) who transfers to this Plan from a non-employer-sponsored plan of "creditable coverage" within 63 days (i.e., with not more than 62 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the other health plan(s). An individual (Employee or Dependent) who transfers to this Plan from another employer-sponsored plan of "creditable coverage" within 180 days (i.e., with not more than 179 days of non-coverage, not counting any days applied toward waiting period requirements), has a right to demonstrate "creditable coverage" and to request a certificate of creditable coverage from the prior health plan(s). This Plan will help any such individual in obtaining such certificate(s). An individual also has the right to demonstrate creditable coverage through the presentation of documentation or other means where a certificate of creditable coverage cannot be obtained from the prior health plan(s).

If the prior coverage is determined to be "creditable coverage", the Plan enrollee will be credited with time covered under such prior plan(s) toward the time limits of this Plan's preexisting condition limitations. If, after creditable coverage has been taken into account, there will still be a preexisting condition limitation imposed on an individual, the individual will be notified to that effect.

"Creditable coverage" includes coverage under a group health plan (including a governmental or church plan), individual health insurance coverage, Medicare (other than coverage solely under § 1928 of the Social Security Act – the program for distribution of pediatric vaccines), Medicaid, military-sponsored health care, a program of the Indian Health Services, a State health benefits risk pool, the Federal Employees Health Benefit Program, The State Children's Health Insurance Program, a public health plan as defined in regulations (i.e., any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), and a health benefit plan under the Peace Corps Act. A coverage can be "creditable coverage" even if such coverage remains in effect.

## PRESCRIPTION BENEFIT SUMMARY

The Plan's prescription drug coverage is provided through **Enloe Pharmacies** and through separate agreement(s) between the Plan Sponsor **and a prescription program vendor** with participating pharmacies. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Covered Persons.

The **Schedules of Prescription Benefits** are on the following page.

This program uses the Express Scripts National Preferred Formulary List.

### PRIOR AUTHORIZATION REQUIREMENTS

The following drugs require prior authorization from the drug program provider. **This list is subject to change – please see [express-scripts.com](http://express-scripts.com) or call Express Scripts to confirm the current list of drugs requiring prior authorization.** It is the Employee's or Covered Person's responsibility to make certain that prior authorization is completed:

- Aranesp inj.
- Botox inj.
- Epogen/Procrit inj.
- Growth promoting agents inj.
- Myobloc inj.
- Prolastin inj. / Aralast inj.
- Regranex
- Revatio
- Tazorac
- Tretinoin for persons over age 40
- Weight management drugs (e.g., Xenical, Meridia)

In order for a Covered Person to obtain a drug that requires prior authorization, the attending Physician must call Express Scripts. Only the Physician (or sometimes a pharmacist) can provide Express Scripts with the information needed to determine if a drug can be dispensed. Express Scripts Prior Authorization phone lines are open 24 hours a day, seven days a week, so that a determination can be made as quickly as possible. The physician prior authorization phone number is (800) 417-8164.

The Physician or pharmacist will be asked questions about the Covered Person's specific condition. If the information provided meets the Plan requirements, the Claimant pays the required Co-Pay at the pharmacy.

As an alternative to obtaining prior authorization, a Claimant can ask his Physician if another medication could be used or he can simply pay the full price for the prescription.

### DRUG QUANTITY MANAGEMENT

The Drug Quantity Management program ensures that the quantity of units supplied for each copayment are consistent with clinical dosing guidelines. The program is designed to support safe, effective and economic use of drugs and thereby, aligns the dispensed quantity of prescription medications with FDA-approved dosage guidelines. Express Scripts maintains a list of drugs in the Plan that are subject to Drug Quantity Limits.

### STEP THERAPY

Drugs in certain ongoing drug therapy categories may be subject to Step Therapy. Step Therapy is a program in which certain drug classes are organized in a set of "steps" with generic drugs being the first step and brand name drugs being the second step.

### SPECIALTY DRUGS

Certain specialty drugs, such as injectables, are available through specialty pharmacies and a program known as CuraScript. After no more than one (1) fill at a retail pharmacy, specialty drugs must be obtained through Express Script's CuraScript program. Patients eligible for the program will be contacted directly by CuraScript. A patient can call CuraScript directly at (800) 278-0980.

### SCHEDULE OF PRESCRIPTION BENEFITS – CLASSIC OPTION

For enrollees in the Classic Option, prescription coverage includes a retail feature with **Enloe Pharmacies** and other participating pharmacies and a mail order feature. **Enloe Pharmacies** and the mail order feature allow a Covered Person to receive a larger quantity of a prescription and are generally useful for long-term or maintenance-type drugs.

PRESCRIPTION FEATURES	Covered Person Pays
<b>Retail Pharmacy Feature</b> <u>Enloe Pharmacies</u> (per 30-day supply) Generic Drug Formulary Brand-Name Drug Non-Formulary Brand-Name Drug  <u>Express Script Pharmacies</u> (30-day supply ONLY) Generic Drug Formulary Brand-Name Drug Non-Formulary Brand-Name Drug	 \$5 Co-Pay† \$10 Co-Pay† \$30 Co-Pay†  \$15 Co-Pay† \$20 Co-Pay† \$40 Co-Pay†
To use the Retail Pharmacy Feature, a Covered Person takes his drug ID card to an <b>Enloe Pharmacy</b> or an Express Scripts participating pharmacy to fill his prescription order. A retail prescription can be purchased in up to a 30-day supply for the Co-Pays shown (although a 60-day or 90-day supply can be obtained from an <b>Enloe Pharmacy</b> at 1 pharmacy visit but a Co-Pay is required for each 30-day supply).	
<b>Mail Order Feature</b> ( <u>Express Script Mail-Order Drugs</u> ) Generic Drug Formulary Brand-Name Drug Non-Formulary Brand-Name Drug	 \$15 Co-Pay† \$30 Co-Pay† \$73 Co-Pay†
The Mail Order Feature is for maintenance (longer-term) drugs. Mail-order drugs are available in up to a 90-day supply for the Co-Pays shown	

### SCHEDULE OF PRESCRIPTION BENEFITS – VALUE OPTION

For enrollees in the Value Option, prescription coverage includes a retail feature with **Enloe Pharmacies**. Other retail participating pharmacies may be used for urgent non-maintenance fills when **Enloe Pharmacies** are closed. **Enloe Pharmacies** also allow a Covered Person to receive a larger quantity of a prescription for long-term or maintenance-type drugs.

PRESCRIPTION FEATURES	Covered Person Pays
<b>Retail Pharmacy Feature</b> <u>Enloe Pharmacies</u> (per 30-day supply) Generic Drug Formulary Brand-Name Drug Non-Formulary Brand-Name Drug  <u>Express Script Pharmacies</u> (up to a 30-day supply – see NOTE 1) Generic Drug Formulary Brand-Name Drug Non-Formulary Brand-Name Drug	 \$10 Co-Pay† \$20 Co-Pay† Not Covered (see NOTE 2)  \$15 Co-Pay† \$20 Co-Pay† Not Covered (see NOTE 2)
To use the Retail Pharmacy Feature, a Covered Person takes his drug ID card to an <b>Enloe Pharmacy</b> to fill his prescription order. A retail prescription can be purchased in up to a 30-day supply for the Co-Pays shown (although a 60-day or 90-day supply can be obtained from an <b>Enloe Pharmacy</b> at 1 pharmacy visit but a Co-Pay is required for each 30-day supply).	
<b>NOTE 1: Purchase of a drug at an Express Scripts pharmacy is limited to no more than a 30-day supply and is permitted for urgent non-maintenance fills – and ONLY when Enloe Pharmacies are closed.</b>	
NOTE 2: A non-formulary drug is not covered unless medically pre-authorized and approved by the medical review panel (i.e., when special circumstance warrant seeking a substitute for a formulary drug and a non-formulary prescription is denied, the patient's Physician may submit a request to Express Scripts for authorization. If approved, the formulary Co-Pay would apply for the non-formulary drug).	

† The Calendar Year Deductible (as reflected in the **Medical Benefit Summary**) does not apply.

## **COVERED DRUGS**

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs which are prescribed by a Physician and which require a prescription either by federal or state law) and certain non-prescription items. Certain drugs are subject to Prior Authorization, Step Therapy and/or Drug Quantity Management. Contact Express Scripts for more information.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans but which are covered by this Plan:

**Contraceptives** - Non-injectable contraceptives (e.g., oral, Ortho Evra, NuvaRing, Seasonale).

NOTE: Injectable contraceptives and contraceptive devices and implants are not covered (e.g., Depo-Provera, Depo-SubQ Provera, Lunelle, Norplant, diaphragms, and IUDs).

**Dermatology Drugs** - Tretinoin agents used in the treatment of acne for Covered Persons through age 40. See "Prior Authorization Requirements" for over age 40.

NOTE: Depigmentation products used for skin conditions requiring a bleaching agent are not covered.

**Diabetic Supplies** - Insulin and diabetic supplies including syringes, needles, insulin injectable devices, pump supplies, swabs, blood monitors and kits, blood test strips, blood glucose calibration solutions, urine tests, lancets, and lancet devices.

### **Estrogen Replacement Drugs**

**Impotence Drugs** - Erectile dysfunction drugs (e.g., Viagra, Levitra, Cialis, Muse, Caverject, Edex).

NOTE: Yohimbine is not covered.

**Injectables** - Injectable drugs, except for allergens.

**Respiratory Supplies** - Respiratory therapy supplies such as aerochambers, spacers or nebulizers;

**Smoking Cessation/Deterrent Drugs, Legend** - Legend smoking cessation products (e.g., Chantix, Zyban, Nicotrol Inhaler). Benefits for smoking cessation products are limited to \$350, per Covered Person, per Lifetime.

**Vitamins, Legend** - Legend vitamins, including prenatal agents and legend fluoride products.

## **EXPENSES NOT COVERED**

Prescription drug coverage will not include any of the following:

**Administration** - Any charge for the administration of a drug.

### **Blood, Blood Plasma & Biological Sera**

**Cosmetic Products** - Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

Hair growth agents such as Propecia and Vaniqa.

Injectable cosmetics such as Botox.

**Devices, Etc.** - Devices even though such devices may require a prescription. These include but are not limited to:

- ◆ peak flow meters;
- ◆ non-insulin syringes; and
- ◆ artificial appliances or braces.

### **Diagnostic, Testing & Imaging Supplies**

**Excess Refills** - Refills which exceed the number of times specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

**Experimental & Non-FDA Approved Drugs** - Experimental drug and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration.

**Fertility Drugs**

**Hair Loss Drugs** - see "Cosmetic Products"

**Homeopathic Drugs** - Homeopathic drugs, legend or non-legend.

**Immunization Agents** - Serums, toxoids or vaccines.

**Investigational Drugs** - A drug or medicine labeled: "Caution – limited by federal law to investigational use."

**No Charge** - A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

**Non-Home Use** - Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

**Ostomy Supplies**

**Over-the-Counter Drugs** - A drug or medicine that can legally be bought without a written prescription. This does not apply to insulin..

**Replacement Prescriptions** - Replacement of a prescription that has been lost, except that replacement of one (1) lost prescription per year will be covered.

**FILING A CLAIM WHEN THE ID CARD  
IS NOT ACCEPTED OR IS NOT AVAILABLE**

When a drug is purchased in a situation where the pharmacy does not accept a Covered Person's Prescription Member ID card or when the Covered Person has not yet received his Prescription Member ID card, then the following claims procedures will apply:

- ◆ A separate prescription claim form must be completed for each pharmacy used and for each patient. The Covered Person (or parent for a child) must read the claim form's "Acknowledgement" carefully and must sign and date the form.
- ◆ Prescription receipts must be submitted with the claim form and each receipt must contain:
  - Date the prescription was filled
  - Name and address of the pharmacy
  - Drug name, strength and NDC (National Drug Code)
  - Rx number
  - Quantity dispensed and day's supply
  - Price
  - Patient's name

The prescription claim form and the prescription receipts must be sent to the prescription Claims Administrator at the following address:

**Express Scripts, Inc.  
P. O. Box 66583  
St. Louis, MO 63166-6583  
Attn: STD Accts**

***PRESCRIPTION BENEFIT SUMMARY, continued***

A claim should be filed within 365 days of the date of purchase. Benefits are based on the Plan's provision at the time the charges were incurred. A claim filed later than that date may be declined or reduced unless: (1) it was not reasonably possible to submit the claim within that time, and (2) the claim is submitted by the end of the Calendar Year following the year in which the claim was incurred. However, this period will not apply when the Covered Person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant.

**DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED HEREUNDER. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER.**

# GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

**Court-Ordered Care, Confinement or Treatment:** Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

**Criminal Activities:** Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, or any injury resulting from a Covered Person being involved in illegal activities or an illegal occupation EXCEPT that this exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

**Drugs in Testing Phases:** Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

**Excess Charges:** Medical charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

**Experimental / Investigational Treatment:** Expenses for treatments, procedures, devices, or drugs which the Plan Sponsor determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded hereunder unless:

- ◆ approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- ◆ reliable evidence shows the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- ◆ reliable evidence shows the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan Sponsor, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *HCFA Medicare Coverage Issues Manual*.

**Forms Completion:** Charges made for the completion of claim forms or for providing supplemental information.

**Government-Operated Facilities:** Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such government.

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

**Late-Filed Claims:** Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

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

**Missed Appointments:** Expenses incurred for failure to keep a scheduled appointment.

**No Charge / No Legal Requirement to Pay:** Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage hereunder. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

## **GENERAL EXCLUSIONS, continued**

**Other Coverage:** Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payer, TRICARE secondary payer, or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

**Outside United States:** Charges incurred outside of the United States, except for Eligible Expenses that are Medically Necessary for Urgent Care or emergency treatment of a Sickness or Accidental Injury.

**Postage, Shipping, Handling Charges, Etc.:** Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

**Prior to Effective Date / After Termination Date:** Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

**Relative or Resident Care:** Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

**Telecommunications:** Advice or consultation given by or through any form of telecommunication.

**Travel:** Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

**War or Active Duty:** Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country.

**Work-Related Conditions:** Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.

## COORDINATION OF BENEFITS (COB)

Except for the prescription benefits described herein, these Plan benefits are subject to Coordination of Benefits as described below.

### DEFINITIONS

In this COB section, the following terms will be capitalized and will have the meanings indicated:

**Other Plan:** Any of the following that provides benefits or services for health care services:

- ◆ group, blanket or franchise insurance coverage;
- ◆ service plan contracts, group practice, individual practice and other prepayment coverage;
- ◆ any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- ◆ Medicare, TRICARE, or other governmental benefits, as permitted by law.

NOTE: If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

**This Plan:** The coverages described herein.

**Allowable Expense:** A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review or utilization management requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

**Claim Determination Period:** A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered hereunder. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan" below).

**Custodial Parent:** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

### EFFECT ON BENEFITS UNDER THIS PLAN

**When Other Plan Does Not Contain a COB Provision:** If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

**When Other Plan Contains a COB Provision:** When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If This Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

## ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. The first of the following rules that describes which plan pays its benefits before another plan is the rule to be used.

**Medicare or TRICARE as an "Other Plan":** Medicare or TRICARE will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

**Non-Dependent vs. Dependent:** The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, Covered Person, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so the plan covering the person as an employee, Covered Person, subscriber or retiree is secondary and the other plan is primary.

**Child Covered Under More Than One Plan:** When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the child's parents are not separated (whether or not they have ever been married), or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they even have been married) or are divorced, the order of benefits is:

- ◆ the plan of the Custodial Parent;
- ◆ the plan of the spouse of the Custodial Parent;
- ◆ the plan of the noncustodial parent; and then
- ◆ the plan of the spouse of the noncustodial parent.

**Active vs. Inactive Employee:** The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

**Longer vs. Shorter Length of Coverage:** If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Claimant for the longer period of time will be determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

## OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

**Right to Receive and Release Necessary Information:** For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits hereunder will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

**Facility of Payment:** A payment made under an Other Plan may include an amount that should have been paid hereunder. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid hereunder. This Plan will not have to pay that amount again.

**Right of Recovery:** If the amount of the payments made by This Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## SUBROGATION AND REIMBURSEMENT PROVISIONS

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

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

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

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

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

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

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

**Right of Reimbursement:** The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

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

The Plan's benefits shall be excess to:

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

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

**Wrongful Death:** In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

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

- ◆ to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- ◆ to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- ◆ to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- ◆ to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- ◆ to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

- ◆ to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

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

**Offset:** Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) may be withheld until the Covered Person(s) satisfies his or her obligation.

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

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

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

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

## ELIGIBILITY AND EFFECTIVE DATES

### **Coverage Options:**

The medical coverage described herein includes optional schedules from which an Employee chooses at point of initial enrollment in the Plan. An Employee must enroll himself and his Dependents (if any are to be enrolled) in the same option. During an annual Open Enrollment, the Plan Sponsor will allow Employees to transfer from one option to another. See "Open Enrollment & Mid-Year Election Changes" (page 49).

### **Eligibility Requirements - Employees:**

To participate in the health coverages described herein, an Employee must be in full-time or part-time active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work at least 48 hours per 2-week pay period.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

### **Effective Date - Employees:**

An eligible Employee's coverage is effective, subject to timely enrollment and following commencement of active employment in a benefit eligible position, on the 1<sup>st</sup> (first) of the month following his date of hire. (Employees hired the 1<sup>st</sup> day of a calendar month will wait one month for benefits. Employees hired the last day of a calendar month will wait one day for benefits.)

An Employee's enrollment is timely only if:

- ◆ he enrolls on or before the day he could first be covered, **OR**
- ◆ if the hire/transfer date is less than ten (10) days before the date the Employee is scheduled to start benefits, the Employee is given ten (10) calendar days from his hire/transfer date to submit the enrollment form.

If an Employee fails to enroll timely, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

### **Eligibility Requirements - Dependents:**

An eligible Dependent of an Employee is:

- ◆ **a legally married spouse** of the Employee. "Legally married" means a legal union as defined by the State of California, but will not include a common law spouse;
- ◆ **a registered domestic partner** when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one partner attains age 62;
- ◆ **a child under age 26 who is not eligible for his employer's plan.** For these purposes a "child" will include the following individuals:
  - a **natural** child;
  - a **stepchild**;
  - a **child who is adopted** by the Employee or placed with him for adoption prior to age 18. The child must be available for adoption and the legal process must have begun. The Employee is required to provide court documentation, satisfactory to the Plan Sponsor, to enroll such a child;
  - a **child placed under the court-appointed legal guardianship** of the Employee. The Employee is required to provide court documentation, satisfactory to the Plan Sponsor, to enroll such a child;
  - a **child** for whom the Employee or covered Dependent spouse is required to provide coverage due to a **Medical Child Support Order** (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a)).

- ◆ a **child of any age who is permanently and totally disabled and incapable of self-sustaining employment**. Employee must initially provide proof of the child's incapacity and dependency within thirty-one (31) days of the date the child is initially eligible for coverage hereunder. Thereafter, continuing proof of incapacity may be requested at reasonable intervals.

An eligible Dependent does **not** include:

- ◆ a spouse following **legal separation** or a final decree of dissolution or **divorce**;
- ◆ any person who is eligible and enrolled as an Employee hereunder;
- ◆ any person who is covered hereunder as a Dependent of another Employee;
- ◆ a child under age 26 who is eligible to enroll in his employer's plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

**Effective Date - Dependents:**

- ◆ **A Dependent who is eligible and enrolled when the Employee enrolls**, will have coverage effective on the same date as the Employee.
- ◆ **Dependents acquired later** may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

**NOTE:** In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

**Special Enrollment Rights & Mid-Year Election Change Allowances**

**Entitlement Due to Loss of Other Coverage:** An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage hereunder at a later date if:

- ◆ he was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- ◆ the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;
- ◆ the individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage (and, on or after April 1, 2009, within sixty (60) days with regard to Medicaid or CHIP - see last sub-entry below).

A loss of coverage event includes but is not limited to:

- loss of eligibility as a result of:
  - legal separation or divorce,
  - cessation of dependent status
  - death of an employee
  - termination of employment
  - reduction in the number of hours of employment
  - a spouse dropping his coverage under his own employer's plan during open enrollment
  - any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

## **ELIGIBILITY AND EFFECTIVE DATES, continued**

- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and
- on or after April 1, 2009, loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the individual becomes eligible for State premium assistance under Medicaid or CHIP.

If one the above conditions is met, coverage hereunder will be effective on the first of the month following loss of other coverage.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

NOTE: An increase in other employer plan premiums, a change in type of medical coverage, or other changes in the benefit package, do not present a special enrollment right.

**Entitlement Due to Acquiring New Dependent(s):** If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and coverage will be effective as follows - see NOTE:

- ◆ where Employee's **marriage** is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the 1<sup>st</sup> of the month following a marriage. Marriage includes the cancellation of a legal separation;
- ◆ where **birth, adoption or placement for adoption** is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends. A newborn adoptive child will be covered from birth if he is placed with the Employee within thirty-one (31) days of birth and is enrolled within that 31-day period.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the Open Enrollment provision.

If a court has ordered that coverage be provided for a covered Employee's minor child, such person may be enrolled as a Dependent hereunder within thirty-one (31) days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party.

### **Newborn & Adoptive Children - Limited Automatic 31-Day Benefit Period**

If a Dependent child is born after the effective date of an Employee's coverage hereunder, benefits will be available for Eligible Expenses of the child which are incurred within the first thirty-one (31) days after birth.

An adoptive child will be eligible for benefits from the date the Employee or spouse has the right to control the child's health care. Evidence of such control includes a health facility minor release report, a medical authorization form, or a relinquishment form. Benefits for such child will be available for a 31-day period only.

After the automatic 31-day benefit period for a newborn or adoptive child, coverage for the child will be available only if, within the 31-day benefit period, the Employee notified the Plan Sponsor or the Contract Administrator and enrolled the child, and agreed to make any required contributions for coverage.

NOTE: During the limited 31-day benefit period, a newborn or adoptive child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons will not apply to a child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

**Open Enrollment & Mid-Year Election Changes**

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period which will be held each year. Plan coverage will be effective the following January 1<sup>st</sup>.

The Open Enrollment period is also a time when an Employee can move from the Value Option to the Classic Option or vice versa.

Any person who is enrolled in the Value Option and who moves beyond the service area, may switch to the Classic Option mid-year.

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

**Reinstatement / Rehire**

If an Employee returns to an eligible status within the same benefit month after termination of coverage, then such Employee (and any of his Dependents who were covered at point of termination) will have coverage become effective the first day of the month following Employee's reinstatement on an active basis.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave the Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires and the Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage hereunder immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Contract Administrator.

**Transfer of Coverage**

If a husband and wife are both Employees and are covered as Employees hereunder and one of them terminates, the terminating spouse, and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

## TERMINATION OF COVERAGE

### Employee Coverage Termination

An Employee's coverage hereunder will terminate upon the earliest of the following:

- ◆ termination of the Plan or termination of the Plan benefits described herein;
- ◆ termination of participation by the Employee's Participating Employer or failure of the Employee to abide by the terms and conditions of the Plan;
- ◆ Employee's election to terminate participation as may be permitted under Article IX of the Enloe Medical Center Section 125 Cafeteria Plan for Employees;
- ◆ at midnight on the last day of the month the covered Employee separates from the employment of the Employer, or ceases to be eligible or engaged in active employment for the required number of hours as specified in the **Eligibility and Effective Dates** section, or becomes an active full-time member of the armed forces of any country - except when coverage is extended under the terms of any **Extension of Coverage** provision.

**NOTE:** Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

### Dependent Coverage Termination

A Dependent's coverage hereunder will terminate upon the earliest of the following:

- ◆ termination of the Plan or discontinuance of Dependent coverage under these benefits of the Plan;
- ◆ eligibility to enroll in his employer's plan;
- ◆ termination of the coverage of the Employee;
- ◆ on the date the Dependent becomes an active full-time member of the armed forces of any country;
- ◆ at midnight on the last day of the month in which the covered Dependent ceases to meet the eligibility requirements except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- ◆ the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). If an Employee submits a drop request, coverage will cease at midnight on the last day of the month. Note that a Dependent being dropped for voluntary purposes will not be eligible for COBRA benefits (see the COBRA section for information on a qualifying event). Also, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination.

- (See **COBRA Continuation Coverage**) -

## EXTENSION OF COVERAGE PROVISIONS

After the termination of coverage date (as determined by the **Termination of Coverage** section), coverage may be continued in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

### **Extensions of Coverage During Absence From Work**

If an Employee fails to continue in active employment but is not terminated from employment (e.g. he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) or as the Enloe Medical Center's leave of absence policies may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- ◆ on the date coverage terminates as specified in the Employer's personnel policies or other employee communications, if any. Such documents are incorporated herein by reference;
- ◆ the end of the period for which the last contribution was paid, if such contribution is required; and
- ◆ the date of termination of the Plan or these benefits of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act.

### **Extension of Coverage During U.S. Military Service**

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who loses coverage because he is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

24 months; or

## **EXTENSION OF COVERAGE PROVISIONS, continued**

the duration of Employee's active military service.

**Reinstatement of Coverage Following Active Duty** - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

within 14 days after active military service ceases for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

### **Extension of Coverage for Retirees**

If an Employee retires from active service with the Employer and;

- ◆ is at least sixty two (62) years of age and has completed at least ten (10) years of service for the Employer; or
- ◆ is at least sixty (60) years of age and has completed at least twenty (20) years of service for the Employer;

then, within sixty (60) days of the date of his retirement, he may elect to continue these coverages without interruption for himself and his eligible Dependents. Coverage for any such person (the retiree or any Dependent) may not be continued beyond the date the person attains age sixty-five (65) and/or becomes Medicare-eligible. If a covered Dependent experiences a COBRA Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for **COBRA Continuation Coverage**. Once the retiree attains age sixty-five, any covered Dependent may be eligible for continuation coverage through COBRA.

Special enrollment rights (see "Special Enrollment Rights" in the **Eligibility and Effective Dates** section) will apply to eligible retirees and their Dependents in the same manner that such rights apply to active Employees and their Dependents. Also, the Plan's restrictions for preexisting conditions may apply in those situations that involve a break in coverage period. See the **Special Restriction for Preexisting Conditions** section for additional information.

The retiree will be required to contribute for extended coverage at the established rates. Contributions must be kept current in order for coverage to remain in effect.

NOTE: Enloe Medical Center reserves the right to modify, revoke, suspend, terminate or change this Extension of Coverage for Retirees, in whole or in part, at any time.

- (See **COBRA Continuation Coverage**) -

# CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

## SUBMITTING A CLAIM

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

For purposes of the Plan, the Plan Administrator, at its discretion, may contract with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities is provided below.

There are two types of claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) **A Pre-Service Claim** is a written or oral request for benefit determination where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care (e.g., a utilization review requirement). See the **Utilization Management Program** section, if any, for that information.

A Pre-Service Claim should be made to the organization identified in the **Utilization Management Program** section or as shown on the Employee's coverage identification card.

**Important: A benefit determination for a Pre-Service Claim shall only be for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A benefit determination for a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.**

- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within one year after the date of such loss. The Plan Sponsor or Contract Administrator reserves the right to deny claims which are not filed with the Contract Administrator for handling within one year after the date the expenses are incurred.

A Post-Service Claim should be submitted to:

**Keenan & Associates  
P. O. Box 2744  
Torrance, CA 90509**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

**Important: These claims procedures address the periods within which benefit determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval, as governed by ERISA.**

### Assignments to Providers

All Eligible Expenses reimbursable hereunder will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

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

**In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.**

No covered Employee or Dependent may, at any time, either while covered hereunder or following termination of coverage, assign his right to sue to recover benefits hereunder, or enforce rights due hereunder or any other causes of action which he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable hereunder.

**CLAIMS TIME LIMITS AND ALLOWANCES**

For group health plans subject to the Employee Retirement Income Security Act (ERISA), the chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

**Important: The stated claims procedures herein address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.**

<b>"PRE-SERVICE" CLAIM ACTIVITY</b>	<b>TIME LIMIT OR ALLOWANCE</b>
<p><b>Urgent Claim</b> - defined below</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p>	<p>Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.</p> <p>Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.</p> <p>Written or electronic notice of a benefit denial or reduction must be provided to the Claimant no later than 3 days after an oral notice.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.</p> <p>Written or electronic notice of a benefit denial or reduction must be provided to the Claimant no later than 3 days after an oral notice.</p> <p>See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.</p>
<p>An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.</p> <p>Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.</p>	

<b>"PRE-SERVICE" CLAIM ACTIVITY</b>	<b>TIME LIMIT OR ALLOWANCE</b>
<p><b>Concurrent Care Claim</b> - defined below</p> <p>Plan Wants to Reduce or Terminate Already Approved Care</p> <p>Claimant Requests Extension for Urgent Care</p>	<p>Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.</p> <p>Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.</p>
<p>A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.</p>	
<p><b>Non-Urgent Claim</b></p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p>	<p>Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.</p> <p>Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p> <p>Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p> <p>See "Appeal Procedures" subsection.</p> <p>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</p>
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.</p>	
<b>"POST-SERVICE" CLAIM ACTIVITY</b>	<b>TIME LIMIT OR ALLOWANCE</b>
<p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p>	<p>Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.</p> <p>Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p> <p>Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p> <p>See "Appeals Procedures" subsection.</p>

Plan Responds to Appeal

Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

#### **Authorized Representative May Act for Claimant**

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

#### **Written or Electronic Notices**

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

## **CLAIMS DENIALS**

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- ◆ the specific reason(s) for the decision to reduce or deny benefits:
- ◆ specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;
- ◆ a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- ◆ a description of any additional information needed to change the decision and an explanation of why it is needed;
- ◆ a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

## **APPEAL PROCEDURES**

#### **Filing an Appeal**

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

#### **Decision on Appeal**

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- ◆ the specific reason(s) for the decision;
- ◆ reference to the pertinent Plan provisions on which the decision is based;
- ◆ a statement that the Claimant 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;
- ◆ identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;
- ◆ a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

## DEFINITIONS

**When capitalized herein, the following items will have the meanings shown below.**

**Accidental Injury:** Any accidental bodily injury which is caused by external forces under unexpected circumstances and which is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

**Ambulatory Surgical Center:** Any public or private establishment which:

- ◆ complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- ◆ has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- ◆ provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- ◆ does not provide services or other accommodations for patients to stay overnight.

**Benefit Document:** A document that describes one (1) or more benefits of the Plan.

**Birthing Center:** A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

- ◆ is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- ◆ is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- ◆ has organized facilities for birth services on its premises;
- ◆ provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;
- ◆ has 24-hour-a-day registered nursing services;
- ◆ maintains daily clinical records.

**Calendar Year:** The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

**Claimant:** Any Covered Person on whose behalf a claim is submitted for benefits hereunder.

**Contract Administrator:** A company which performs all functions reasonably related to the general management, supervision and administration of certain benefits of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

**Convalescent Hospital:** see "Skilled Nursing Facility"

**Covered Person:** A covered Employee or covered retiree, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information. (A covered Employee or covered retiree, a covered Dependent, and a Qualified Beneficiary may also be referred to as a Member.)

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

**Covered Provider:** An individual who is:

- ◆ **licensed** to perform certain health care services which are covered hereunder and who is acting within the scope of his license; or
- ◆ **in the absence of licensing requirements, is certified** by the appropriate regulatory agency or professional association;

**and** who is a/an:

- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dentist (DDS or DMD)
- Dental Technician
- Enterostomal Therapist
- Laboratory Technician
- Licensed Clinical Psychologist (PhD or EdD)
- Licensed Clinical Social Worker (LCSW)
- Licensed Practical Nurse (LPN)
- Licensed Psychiatric Nurse
- Licensed Vocational Nurse (LVN)
- Marriage Family and Child Counselor (MFCC),
- Medical Social Worker (MSW)
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physician Assistant
- Physical Therapist (PT or RPT)
- Physician - see definition of "Physician"
- Podiatrist or Chiropodist (DPM, DSP, or DSC)
- Prosthetist or Prosthetist/Orthotist
- Registered Nurse (RN)
- Research Psychoanalyst
- Respiratory Therapist
- Speech Therapist or Pathologist

A **"Covered Provider"** will also include the following when appropriately-licensed and providing services which are covered hereunder:

- ◆ any practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his license;
- ◆ facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;
- ◆ licensed Outpatient mental health facilities;
- ◆ freestanding public health facilities;
- ◆ hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- ◆ enuresis control centers;
- ◆ portable X-ray companies;
- ◆ independent laboratories;
- ◆ blood banks;
- ◆ ambulance companies;
- ◆ nurses registry;
- ◆ licensed rehabilitation clinics;
- ◆ speech and hearing centers;
- ◆ dental labs and dental supply companies;
- ◆ Easter Seal Society, American Cancer Society and Catholic Charities.

NOTE: A Covered Provider does not include a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**.

**Dependent:** see the **Eligibility and Effective Dates** section

**Eligible Expense(s):** Expense which is: (1) covered by a specific benefit provision of the Benefit Document, and (2) incurred while the person is covered by the Plan.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of 1867(e)(1)(A) of the Social Security Act.

**Employee:** see **Eligibility and Effective Dates** section

**Employer(s):** The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

**Fiduciary:** A Plan entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

**Home Health Care Agency:** An agency or organization which:

- ◆ is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- ◆ has policies established by a professional group associated with the agency or organization which includes at least one registered nurse (RN) to govern the services provided;
- ◆ provides for full-time supervision of such services by a Physician or by a registered nurse;
- ◆ maintains a complete medical record on each patient;
- ◆ has a full-time administrator.

In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

**Hospice:** An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

**Hospital:** An institution which:

- ◆ complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- ◆ is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients;
- ◆ is operated under the supervision of a staff of Physicians;
- ◆ continuously provides 24-hour-a-day nursing service by registered nurses;
- ◆ maintains facilities for diagnosis of injury or disease;
- ◆ maintains permanent facilities for major surgical operations on its premises; and
- ◆ is not, other than incidentally: (1) a place of rest, for custodial care, for the aged, or for the care of senile persons, (2) a nursing home, (3) a hotel, or (4) a school or similar institution.

For treatment of mental health conditions or substance use disorders, a "Hospital" will also include: (1) a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations, (2) a facility operated primarily for the treatment of alcoholism and accredited by the Joint Commission on Accreditation of Healthcare Organizations, and (3) a facility defined as a "psychiatric health facility" in Section 1250.2 of the California Health and Safety Code. In no instance will a residential treatment facility, by whatever name called, be deemed a "Hospital."

**Inpatient:** A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

**Intensive Care Unit (ICU)** (or Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit): A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

**Medically Necessary:** Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- ◆ it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;
- ◆ the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
- ◆ it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and
- ◆ it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listing in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

**Medicare:** Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

**Outpatient:** Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

**Participating Employer:** An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

**Physician:** A Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

**Plan:** The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

**Plan Administrator:** see "Plan Sponsor"

**Plan Document:** A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

**Plan Sponsor:** The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

**Pregnancy & Pregnancy Care:** Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

**Semi-Private Room Charge:** The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

**Sickness:** Bodily illness or disease (including covered mental health conditions and covered substance use disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness.

**Skilled Nursing Facility:** An institution which:

- ◆ is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- ◆ is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- ◆ is under the full-time supervision of a Physician or a registered nurse;
- ◆ admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;
- ◆ has established methods and procedures for the dispensing and administering of drugs;
- ◆ has an effective utilization review plan;
- ◆ is approved and licensed by Medicare;
- ◆ has a written transfer agreement in effect with one or more Hospitals; and
- ◆ is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

**Urgent Care:** Services rendered for a sudden, serious or unexpected illness, injury or condition, which is not an Emergency Medical Condition, but requires immediate care for the relief of pain or diagnosis and treatment of such condition.

**Urgent Care Facility:** A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- ◆ a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- ◆ X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

**Usual, Customary and Reasonable (UCR):** A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

With regard to charges made by a provider of service participating in the Plan's Network program, Usual, Customary and Reasonable will mean the provider's negotiated rate - but not to exceed the actual charge or the non-Network Usual, Customary and Reasonable allowance unless such lesser amount is not permitted under the terms of the Network agreement.

## GENERAL PLAN INFORMATION

<b>Name of Plan:</b>	<b>Enloe Medical Center Employee Welfare Benefit Plan</b>
<b>Plan Sponsor / Plan Administrator:</b> Address:	<b>Enloe Medical Center</b> 1531 Esplanade Chico, CA 95926
Business Phone Number:	(530) 332-7344
<b>Participating Employer(s):</b>	<b>Enloe Medical Center</b>
<b>Plan Sponsor ID Number (EIN):</b>	<b>94-1603784</b>
<b>Plan Number:</b>	<b>501</b>
<b>Plan Year:</b>	<b>January 1 through December 31</b>
<b>Original Plan Effective Date:</b>	<b>April 1, 1987</b>
<b>Named Fiduciary:</b> Address:	<b>Enloe Medical Center</b> 1531 Esplanade Chico, CA 95926
(See also definition of "Fiduciary")	
<b>Agent for Service of Legal Process:</b> Address:	<b>Enloe Medical Center</b> 1531 Esplanade Chico, CA 95926
(Legal process may be served upon the Plan Sponsor or a Fiduciary)	
<b>Type of Plan:</b>	<b>This is an employee welfare benefit plan providing group benefits</b>
<b>Plan Benefits Described Herein:</b>	<b>Self-Funded Medical &amp; Prescription Drug Benefits</b>
<b>Type of Administration:</b>	<b>Contract Administration</b> – see "Administrative Provisions" for additional information
<b>Applicable Collective Bargaining Agreement(s):</b>	<b>(see "Collective Bargaining Agreement(s)" in the Administrative Provisions, below)</b>
<b>Contract Administrator:</b> Street Address:	<b>Keenan &amp; Associates</b> 2355 Crenshaw Boulevard, Suite 300 Torrance, CA 90501
Phone:	(310) 212-0363
Enloe Customer Service Number:	(877) 365-6399 or (877) Enloe99

## FUNDING - SOURCES AND USES

### Employee & Employer Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a Section 125 pre-tax premium plan.

See the **COBRA Continuation Coverage** section for more information.

### Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with ERISA guidelines.

## ADMINISTRATIVE PROVISIONS

### Administration (type of)

The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

### Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's 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 do not exceed the total benefits to which the Claimant would otherwise be entitled hereunder in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

### Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- ◆ reduce, modify or terminate retiree health care benefits under the Plan, if any;
- ◆ alter or postpone the method of payment of any benefit;
- ◆ amend any provision of these administrative provisions;
- ◆ make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- ◆ terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

### Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

### Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

### Collective Bargaining Agreement(s)

This Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor, and is available for examination by Covered Person and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

**Creditable Coverage Certificates** - Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the

person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

**Discrepancies**

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

**Facility of Payment**

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

**Fiduciary Responsibility, Authority and Discretion**

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

**Force Majeure**

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

**Gender and Number**

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

**Illegality of Particular Provision**

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

**Indemnification**

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

**Legal Actions**

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits hereunder will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

**Loss of Benefits**

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- ◆ an employee's cessation of active service for the employer;
- ◆ a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- ◆ a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- ◆ a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- ◆ a claim for benefits is not filed within the time limits of the Plan;
- ◆ misstatement/misrepresentation;
- ◆ fraud or intentional misrepresentation.

**Material Modification**

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

**Misstatement / Misrepresentation**

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

**Misuse of Identification Card**

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

**Non-Discrimination Due to Health Status**

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

**Physical Examination**

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

**Plan Administrator Discretion & Authority**

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

**Privacy Rules & Security Standards & Intent to Comply**

To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

**Purpose of the Plan**

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

**Rescission of Coverage**

The Plan may rescind an individual's coverage under the Plan (i.e., retroactively), upon 30 day's notice, upon a showing that a Covered Person has engaged in fraud or made an intentional misrepresentation of a material fact.

**Reimbursements**

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

**Rights Against the Plan Sponsor or Employer**

Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

**Titles or Headings**

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

**Workers' Compensation**

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

# STATEMENT OF RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

**Receive Information About His/Her Plan and Benefits.** This includes the right to:

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

obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

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

**Continue Group Health Plan Coverage.** This includes:

the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights; and

reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan, when he/she becomes entitled to elect COBRA continuation coverage, when his/her COBRA continuation coverage ceases, if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after his/her enrollment date in the Plan.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

**Enforce His/Her Rights**

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to \$110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

**Assistance With His/Her Questions**

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

**Definitions** - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary – An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or registered domestic partner of the Employee or child of the covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources with the United States. If such an Employee is not a Qualified Beneficiary, then a spouse, registered domestic partner or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event – Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse, registered domestic partner or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his Medicare coverage is in effect.

for an Employee's spouse, registered domestic partner or child, the divorce or legal separation of the Employee and spouse or registered domestic partner;

for an Employee's spouse, registered domestic partner or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses, registered domestic partners and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U. S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin."

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

**Notification Responsibilities** – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included at the front of this document (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

**Election and Election Period** - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

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

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

**Effective Date of Coverage** - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

**Level of Benefits** - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

**Cost of Continuation Coverage** - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;

- the increase is due to a rate increase at Plan renewal;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

- the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

**Maximum Coverage Periods** - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

**Disability Extension** - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

**Termination of Continuation Coverage** - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

**Effect of the Trade Act** - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

#### Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual - A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual - An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period - with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage - means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

#### HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

#### Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

