PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

FOR THE MIDLAND COUNTY EMPLOYEE MEDICAL AND DENTAL BENEFIT PLANS EFFECTIVE JANUARY 1, 2019, PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

Boon-Chapman Benefit Administrators, Inc.
9401 Amberglen Boulevard
Suite 100
Austin, TX 78729

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Plan Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator:

Signed (authorized representative of Plan Sponsor) Date

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MIDLAND COUNTY

EMPLOYEE MEDICAL AND DENTAL BENEFIT PLANS

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

EFFECTIVE: JANUARY 1, 2019

Administered by:

BOON-CHAPMAN

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SPECIAL NOTICES

As a non-federal governmental plan, Midland County is exercising its privilege to opt-out of the Health Insurance Portability and Accountability Act (HIPAA) effective October 1, 1997, as it relates to The Newborns and Mothers Health Protection Act.

GRANDFATHERED HEALTH PLAN

The County believes its Medical Plan is a "grandfathered health plan" (GFP) under the Patient Protection and Affordable Care Act (PPACA). Accordingly, a GFP can preserve certain basic health coverages already in effect as of the day the law was enacted. Being a GFP means our Plan may not include certain provisions of PPACA that may apply to other plans, such as the requirement of coverage with no cost sharing for specific preventive health services. However, GFPs must comply with other Provisions in the PPACA, such as the elimination of lifetime limits on the minimum essential benefits. Questions? Please call the County Treasurer's Office at (432) 688-4880 or Boon-Chapman at (800) 252-9653. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

COBRA NOTIFICATION PROCEDURES

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 COBRA Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is 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 made in writing. Notice may be made by submitting the "Notice of Qualifying Event" form and mailing it to the COBRA Administrator. This form is available, without charge, from the Plan Sponsor.

Content - Notification must include an adequate description of the Qualifying Event or disability determination. In the case of a disability determination, a copy of the Social Security Administration determination of disability must be included. The Qualified Beneficiary must also provide any additional information as the Plan deems

necessary for making the appropriate determination with regard to the Notice e.g. evidence of the specific event which would indicate a divorce decree, child's birth certificate, etc.

Delivery of Notification - Notification must be received by the COBRA Administrator at:

Mail: Midland County
2110 N. "A" Street
Suite 167
Midland, TX 79705

The phone number for assistance with COBRA questions is 800-252-9653.

Time Requirements for Notification - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee or family member must provide Notice to the designated recipient within a certain timeframe. The notice must be received in the COBRA Administrator's office within thirty (30) days of the occurring event.

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 a 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 a 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.

The Women's Health and Cancer Rights Act

Under Federal law, the health benefits of most 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.

Plan participants 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).

Who to Contact for Additional Information

A Plan participant can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

The Plan Sponsor has contracted with a Utilization Management Organization to provide preauthorization services. The name and phone number of the organization is shown on the Employee's coverage identification card.

The procedures outlined below must be followed to avoid a penalty for non-compliance.

PREAUTHORIZATION REQUIREMENTS

The Notification Procedure - The Utilization Management Program requires that the Covered Person, his attending Physician, or a member of his family contact the Utilization Management Organization as follows:

- for a scheduled hospital admission, including pregnancy – as far in advance as possible, so that the attending physician can submit the preauthorization certification form to the Utilization Management Organization at least ten (10) working days prior to the date of the scheduled admission. Pregnancies must have the preauthorization certification process completed by the seventh (7^{th}) month of the pregnancy;

- for an urgent admission – immediately prior to the actual admission. An urgent admission is a hospital admission that is not an emergency admission, but is necessary within at least 72 hours from the time a physician recommends such hospital confinement;

- for an emergency hospital admission - within 48 hours following admission (72 hours on weekends and national legal holidays). An emergency admission is an admission that may not be scheduled at the convenience of the physician and patient without endangering the patient's life or bodily functions.

The following information needs to be provided to the Utilization Management Organization:

- the Employee's name, address and Social Security number;
- the patient's name, address, telephone number, date of birth and sex;
- the name, address and telephone number of the attending physician and the hospital;
- the reason for the hospital confinement
- the expected (or, if an emergency, the actual) date of admission; and,
- the name of the Plan – Midland County Employee Medical and Dental Benefit Plan

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 Utilization Management Organization no later than the last authorized day.

Penalty for Non-Compliance - If the preauthorization requirements are not completed for a Hospital admission, an additional Deductible of $250 will be applied before Plan benefits are determined. In addition, if the Utilization Management Organization determines that any Inpatient days were not Medically Necessary, no benefits will be payable for those days.

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

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval 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 PREAUTHORIZATION

It is the Employee 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.

Prior 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 under the Plan 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 which is not Medically Necessary or which is otherwise not covered under 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.

CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

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 a voluntary service. There are no reductions of benefits or penalties if the patient and family choose 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

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with a Network of health care providers. When obtaining health care services, a Covered Person has the choice of using providers who are participating in the Network, or providers who do not participate in the Network. All Non-Network providers must be Covered Providers under the Plan.

Network providers have agreed to provide services to Covered Persons at negotiated rates. As a result, a Covered Person may incur lower out-of-pocket costs when using Network providers, since a Network provider cannot bill for expenses in excess of these negotiated rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers, as shown in the Schedule of Medical Benefits.

A directory of Network providers is available, without charge, at the website shown on the Employee's ID card. Covered Persons are encouraged to refer to this directory before scheduling appointments, to verify that the provider is a Network provider. Please note that certain covered services and supplies may not be available through the Network.

Non-Network providers will receive Network benefits for the following services based on the Plan's Maximum Eligible Charge guidelines.

No Choice of Provider – If, while receiving treatment at a Network facility, a Covered Person receives ancillary services from a Non-Network provider in a situation in which he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist, hospitalist or a provider for diagnostic services), such ancillary services will be payable at the Network benefit level.

Medical Emergency – In a Medical Emergency (see "Medical Emergency" in the **Definitions** section), a Covered Person should try to access a Network provider for treatment. However, if immediate treatment is required and accessing a Network provider is not possible, the services of Non-Network providers will be covered at the Network benefit levels until the patient's condition has stabilized to the extent that he can be safely transferred to Network provider care. At that point, if the transfer does not take place, subsequent charges incurred with a Non-Network provider will be payable at the Non-Network benefit level.

Specialist Care Not Available In-Network – If a Covered Person requires the care of a specialist, and such specialist care is not available in the Network, or is not available within a reasonable distance, benefits for such Non-Network specialist care will be payable at the Network benefit levels.

No Network Provider Within 50-Mile Radius – If a Network provider (facility or physician) qualified to provide Medically Necessary care for a Covered Person is not available within a 50-mile radius from the Covered Person's home address, benefits for such care received from a Non-Network provider will be payable at Network benefit levels.

AFFECT ON BENEFITS

Simply because a service or supply is listed in this Plan Document as a Covered expense does not necessarily mean it will be a Covered expense for a specific Covered Person. In order for an expense to be a Covered expense for a specific Covered Person, that expense must be deemed Medically Necessary for that individual; and must comply with all other terms and conditions of the Plan.

SCHEDULE OF MEDICAL BENEFITS

BENEFIT MAXIMUMS

Amounts credited towards individual Maximums are also credited towards the Lifetime Maximum Benefit. Once the Lifetime Maximum Benefit is met, no additional benefits are available under the Plan. Once a Maximum Benefit for a specified service is met, no additional benefits for that service are available for the remainder of the time period specified. The Maximum Benefits specified below are per Covered Person.

Lifetime Maximum Benefit	UNLIMITED
Chiropractic Care	25 visits per Calendar Year
Home Health Care	100 visits per Calendar Year.
Morbid Obesity	One (1) per Lifetime
Sleep Disorders	$5,000 Lifetime Maximum Benefit; $250 per Calendar Year renewable benefit

CALENDAR YEAR DEDUCTIBLES

Except as specified otherwise, Covered Expenses are subject to a Calendar Year Deductible that must be met before benefits are payable. The Individual Deductible is satisfied once a Covered Person has paid the Individual Deductible amount. The Family Deductible is satisfied once amounts credited towards the Individual Deductibles of a family total the Family Deductible amount. Once the Family Deductible is satisfied, all Individual Deductibles for that family are considered to be satisfied for the remainder of that Calendar Year.

Amounts applied to the Network and Non-Network Deductibles shown below will apply towards each other. This means amounts incurred with Network providers are credited toward both the Network and Non-Network Deductibles, as well as, the amounts incurred with Non-Network providers are credited toward both the Network and Non-Network Deductibles.

Deductible Amounts	**Network**	**Non-Network**
Individual	$600	$1,200
Family with 2 Members	$750	$1,400
Family with 3 or more Members	$850	$1,400

CALENDAR YEAR OUT-OF-POCKET MAXIMUMS

Most Covered Expenses are paid by the Plan at less than one hundred percent. The remaining percentage of the expense, known as "co-insurance", must be paid by the Covered Person. Except as specified below, co-insurances paid by a Covered Person are credited towards that person's Out-of-Pocket Maximum. The Individual Out-of-Pocket Maximum is satisfied once a Covered Person has paid the Individual Out-of-Pocket Maximum amount.

Amounts applied to the Network and Non-Network Out-of-Pocket Maximums shown below will apply towards each other. This means amounts incurred with Network providers are credited toward both the Network and Non-Network Out-of-Pocket Maximums, as well as, the amounts incurred with Non-Network providers are credited toward both the Network and Non-Network Out-of-Pocket Maximums.

Once an Out-of-Pocket Maximum has been satisfied, all remaining Covered Expenses for that Covered Person incurred during that same Calendar Year will be payable by the Plan at one hundred percent, except as specified below. There is no Family Out-of-Pocket Maximum.

If a Covered Person (including an Employee) has coverage under another group health plan, then no Out-of-Pocket Maximum shall apply under this Plan.

Out-of-Pocket Maximums	**Network**	**Non-Network**
Individual	$3,000	$8,000
Expenses Not Credited Toward the Out-of-Pocket Maximum	• Deductibles • Co-Pays • Penalties for failure to comply with the Utilization Management Program, including any portion of a hospital stay that is not certified by the Utilization Management Program as being Medically Necessary • Non-Covered Expenses • Expenses in excess of any Maximum Benefit • Amounts in excess of the Plan's Maximum Eligible Charge • Expenses processed under the Prescription Drug Program • Expenses paid at a Benefit Percentage of 100% • Mental/Nervous Disorders expenses	

IMPORTANT: CERTAIN HEALTH CARE SERVICES MAY REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

ELIGIBLE MEDICAL EXPENSES

This schedule shows the percentage payable by the Plan for a Covered Expense after any Deductible, if applicable, has been satisfied. The percentages shown are applied to the "Maximum Eligible Charge" amount for an expense. For Network providers, that amount is based on negotiated rates. After finding the percentage payable for an expense in this schedule, please refer to the section **Eligible Medical Expenses** for any terms or conditions that apply to that expense.

	Network	**Non-Network**
Ambulance	80% after Deductible	80% after Deductible
Chiropractic Care Calendar Year Maximum = 25 Visits	50% after Deductible	50% after Deductible
Diabetic Supplies Through Edgepark Medical Supplies	100%, Deductible waived	100%, Deductible waived
Lab Services through LabCard by Quest	100%, Deductible waived	100%, Deductible waived
Diagnostic Lab & X-Ray – Independent Facility	80% after Deductible	50% after Deductible
Extended Care Facility	80% after Deductible	50% after Deductible
Home Health Care Calendar Year Maximum = 100 visits	80% after Deductible	50% after Deductible
Hospice Care	80% after Deductible	50% after Deductible
Hospital Services		
Inpatient Care	80% after Deductible	50% after Deductible
Outpatient Services, Including Emergency Room	80% after Deductible	50% after Deductible
Physician Services		
Telemedicine Visit Speak to a licensed doctor through Teladoc 24/7/365	$0 Co-pay	N/A
Office Visits/Injections The co-pay applies even if additional co-pays are applied for same-day services.	100% up to $100/visit after a $25 Co-pay, Deductible waived, then 80% after Deductible	50% after Deductible
Lab Work – Physician's Office The co-pay applies even if additional co-pays are taken for same-day services.	100% up to $50/visit after a $25 Co-pay, Deductible waived, then 80% after Deductible	50% after Deductible
X-Rays – Physician's Office The co-pay applies even if additional co-pays are taken for same-day services	100% up to $50/visit after a $25 Co-pay, Deductible waived; then 80% after Deductible	50% after Deductible
Pregnancy Expenses Preauthorization must be completed by the seventh month		
Maternity Expenses	80% after Deductible	50% after Deductible
Newborn Expenses (includes circumcision if performed within the first 4 days)	80% after Deductible	50% after Deductible
Preventive Care Includes all charges related to preventive/wellness care, including immunizations and an annual vision exam. • First $1,500 in payable benefits per Calendar Year • Eligible amounts in excess of $1,500	100%, Deductible waived 80% after Deductible	100%, Deductible waived 80% after Deductible
Second and Third Surgical Opinions	100%, Deductible waived	100%, Deductible waived
Sleeping Disorders Lifetime Maximum = $5,000	80% after Deductible	50% after Deductible

IMPORTANT: CERTAIN HEALTH CARE SERVICES MAY REQUIRE PRIOR AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION.

ELIGIBLE MEDICAL EXPENSES

This schedule shows the percentage payable by the Plan for a Covered Expense after any Deductible, if applicable, has been satisfied. The percentages shown are applied to the "Maximum Eligible Charge" amount for an expense. For Network providers, that amount is based on negotiated rates. After finding the percentage payable for an expense in this schedule, please refer to the section **Eligible Medical Expenses** for any terms or conditions that apply to that expense.

	Network	**Non-Network**
• After Lifetime Maximum is reached, there is a $250 per Calendar Year renewable benefit available for repair/replacement services. • Services must be preauthorized & must be performed in a Certified Sleep Lab.		
Urgent Care Facility	100% up to $100/visit after a $25 Co-pay, Deductible waived; then 80% after Deductible	50% after Deductible
All Other Covered Medical Expenses	80% after Deductible	50% after Deductible

Outpatient Dialysis Treatment All Providers	100% of MEC

Important Note: The plan does not use a preferred provider organization (PPO) for dialysis services. The definition of MEC is different for Outpatient Dialysis Services than other services. Please review the definition of "Maximum Eligible Charges" also referred to as "MEC", which is contained in the Section titled "Definitions" for details.

A Covered Person Must: (1) notify American Health Holdings when Dialysis treatment begins; (2) notify American Health Holdings when diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.

Please see "Choice of Providers" for situations in which Non-Network Covered Expenses are payable at Network benefit levels.

CARVE-OUT TRANSPLANT BENEFIT

Transplant Benefits:

You have organ and tissue transplant coverage under a separate insurance policy provided by Tokio Marine HCC – Stop Loss Group (TMHCC) and issued either by National Union Fire Insurance Company of Pittsburgh, Pa. or HCC Life Insurance Company. Such coverage pays benefits for certain organ and tissue transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact TMHCC's Transplant Unit toll-free at 1-888-449-2377 for benefit information, pre-authorization of transplant services, and transplant network provider access.

Pre-Authorization of Transplant Services
Pre-authorization of transplant services is required prior to seeing a transplant provider for a consult and/or evaluation. Failure to do so could result in reduced benefits.

NOTICE- Transplant Network
In order to obtain 100% in-network benefits, you must use providers in a transplant network approved by and accessed through TMHCC's Transplant Unit. Expenses billed by the transplant network provider that are not covered by the TMHCC policy are subject to this medical plan's benefits and the payment terms and conditions of the transplant network provider's contracted rates.

For more information, contact your medical plan administrator and or human resources department.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. Services and supplies must be approved by a Physician or other appropriate Covered Provider; must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition; and must be received from a Covered Provider.

Except as otherwise noted below, benefits are based on the Maximum Eligible Charge for that expense, incurred by a Covered Person, and are subject to the **Definitions**, **Limitations and Exclusions** and all other terms and conditions of the Plan.

Please refer to the **Schedule of Medical Benefits** to determine what percentage of each Covered Expense is payable by the Plan.

For benefit purposes, medical expenses shall be deemed to be incurred on:

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

Abortion – Charges for an elective abortion, but only when the life of the mother would be endangered if the fetus were carried to term. NOTE: Complications arising out of an abortion are covered as any other Sickness.

Allergy Care - Charges in connection with allergy shots and allergy testing.

Ambulance - professional ambulance service to the nearest facility where emergency care or treatment can be rendered, or to the nearest facility equipped to furnish Medically Necessary treatment when specialized treatment is not available at a local hospital. When an individual is being transferred from a Hospital or Extended Care Facility to receive Home Health Care or Hospice Care at home, transportation by ambulance from the facility to the individual's home will also be eligible if Medically Necessary. Transportation other than by standard ground ambulance is covered for regularly scheduled air flights, railroad and air ambulance, only if such mode of transport is Medically Necessary.

Ambulatory Surgical Center - Ambulatory surgical center services rendered within 24 hours from, and in connection with, a surgical procedure, or within seven (7) consecutive days before the procedure in the case of diagnostic procedures.

Blood – Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

Braces - Braces required for the mobilization and restoration of an impaired function, or initial braces, crutches, casts and splints to improve function when the loss or impairment of function occurred while covered under this Plan.

Chemical Dependency – See "Mental/Nervous Disorders and Substance Abuse".

Chiropractic Care – See "Professional Services".

Circumcisions - Circumcisions whether performed on an inpatient or outpatient basis.

Contact Lenses - Initial contact lenses or glasses if required following cataract surgery.

Contraception - Charges for Depo Provera, Norplant, IUDs and other forms of birth control. Oral Contraceptives are covered under the Prescription Drug Plan.

Cosmetic Surgery - Charges in connection with Cosmetic Surgery are covered only:

a. for the correction of a birth defect; or

b. for replacement of diseased tissue surgically removed;

c. with Pre-Authorization by the Contract Administrator.

Dental Services – Limited to ONLY the following services:

- Accidental Injury - For treatment of a fractured jaw or injury to sound natural teeth due to accidental injury. Charges must be incurred within 12 months of the accident.
- Oral Surgery, limited to the following procedures:
  - Excision of tumors or cysts from the mouth;
  - Apicoectomy (excision of tooth root without extraction of the tooth);
  - Treatment of fractures of facial bones;
  - Removal of impacted wisdom teeth.

Diabetic Services - Eligible expenses for diabetic supplies and clinitest for diagnosed diabetes (syringes and needles covered under the Prescription Drug Program). Also includes education and training or instruction for diabetic care.

Diagnostic Services - Diagnostic x-ray and laboratory service.

Drugs – Drugs and medicines requiring a physician's prescription (including prenatal vitamins and oral contraceptives if prescribed by a physician). Outpatient prescription drugs are only covered under the Prescription Drug Program.

Durable Medical Equipment - Rental equipment that is medically necessary and appropriate for the therapeutic treatment of a covered illness or a covered injury. Durable Medical Equipment is normally found in a hospital setting and cannot be considered as a household item for use by other family members or for the comfort and convenience of the patient or family.

Experimental or Investigational - When receiving experimental/investigational chemotherapy or radiation treatment for cancer, an amount, which is equal to the cost of standard chemotherapy treatment for the condition, will be considered as a covered expense. Such amount will be established by the Contract Administrator in conjunction with the medical provider used, but will not include the expenses for any drug not approved by the FDA or any tests to evaluate the effect of such drug therapy or treatment.

Extended Care Facility - Extended care facility or skilled nursing facility services and supplies as listed below, when furnished to a Covered Person for his use during confinement in the facility, and by means of a transfer from a hospital in which he was confined for at least three (3) consecutive days or confined within fourteen (14) days after hospital discharge, and is for continued care of the same condition(s) which resulted in that hospital confinement.

The following are extended care facility services and supplies:

a. Room and board;

b. Routine nursing care, but not including the services of a private-duty nurse or other private-duty attendant;

c. Physical therapy, occupational therapy, and speech therapy provided by the extended care facility or by others under arrangements with such facility;

d. Medical social services;

e. Such biologicals, supplies, appliances, and equipment as are ordinarily provided by the extended care facility for the care and treatment of its inpatients;

f. Diagnostic and therapeutic services furnished to inpatients of the extended care facility by a hospital; and

g. Such other services necessary to the health of patients as are generally provided by extended care facilities (excluding, however, any item or service, which would not be provided to an inpatient of a hospital).

Hearing Aids - Hearing aids (including cochlear implants) and the examination for the prescription when an injury to the internal ear or illness results in permanent hearing loss and which occurred while covered under this Plan.

Home Health Care (Limited to 100 visits per Calendar Year. For services or supplies furnished by a Home Health Care Agency for the sole purpose of treating a disabling illness or injury in accordance with a home care plan.

a. Part-time or intermittent nursing care by a registered professional nurse (R.N.) or by a licensed practical nurse under the supervision of a registered nurse;

b. Physical therapy, occupational therapy and speech therapy provided by the Home Health Care Agency; and

c. Medical supplies, drugs, and medications prescribed by a physician and laboratory services by or on behalf of a hospital to the extent such items would have been covered under this benefit if the Covered Person had been confined in the hospital.

Hospice - Covered Expenses are limited to hospice care approved every thirty (30) days by the utilization management organization. In addition, Covered Expenses are limited to charges for the following services provided by a Hospice Care Program for the care of a Covered Person with a Physician-diagnosed life expectancy of 6 months or less:

a. nursing care by a licensed registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed vocational nurse (L.V.N.), or a public health nurse who is under the direct supervision of a licensed registered graduate nurse (R.N.);

b. medical services, supplies, and drugs; or

c. Physician's services.

In addition, bereavement counseling is a Covered Expense if provided by a Hospice Care Program to a Covered Person's spouse, children, or parents within three months of the death of a Covered Person who was in a Hospice Care Program at the time of death. See Schedule of Benefits for possible limitations.

Hospital Care - Hospital care in a "hospital" as defined herein, for room, board, and other hospital services required for purposes of treatment.

Jobst Stockings - Charges for jobst stockings when medically necessary, limited to 3 per calendar year.

Learning Disability - Charges incurred for the treatment of a learning disability (by any name called) ONLY if the learning disability is medically related. Eligible charges shall include physician office visits for medicine check-ups and the medication, psychological testing, outpatient care, inpatient care and day treatment. Benefits are eligible under the psychiatric benefits of the plan and subject to the limitations as indicated on the schedule of benefits.

Maternity Expenses (Preauthorization must be completed by the seventh month) - Expenses incurred for maternity care and services. Covered Expenses shall include eligible charges for a birthing center and other medically necessary care and services received in connection with a pregnancy.

Mental/Nervous Disorders and Substance Abuse - the treatment of mental or nervous disorders at a hospital for treatment on an inpatient or outpatient basis, through a Partial Hospitalization Treatment program, or for services rendered by a Psychiatrist, Psychologist, Licensed Clinical Social Worker or other counselor authorized by his or her state of practice to provide counseling services. As used in this provision, the following terms have the defined meaning:

- a "Mental/Nervous Disorder" means any diagnosis listed in the *Mental Disorders* section of the current edition of the International Classification of Diseases, other than diagnoses listed under Alcohol and Drug Psychoses, Alcohol and Drug Dependence Syndrome and Nondependent Abuse of Drugs;
- a "Partial Hospitalization Treatment Program" means a program provided through a hospital which provides psychological therapy on an outpatient basis as an alternative to inpatient confinement or provides transitional support following inpatient treatment and which meets the following requirements:
    a. provides care by one or more program therapists who are credentialed by the state in the field;
    b. is under the full supervision of a physician; and,
    c. maintains complete medical records on each patient.

Inpatient and Outpatient effective treatment of addiction resulting from substance abuse. "Effective treatment" means a program that meets all of the following requirements:

- it is prescribed and supervised by a Physician;
- the Physician certifies that a follow-up program has been established which includes therapy by a Physician, or group therapy under a Physician's direction, at least once per month; and

- it includes meetings of organizations devoted to the therapeutic treatment of substance abuse at least twice per month.

For Plan purposes, "substance abuse" is physical and/or psychological 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.

Morbid Obesity (Surgical and non-surgical treatment for morbid obesity must be preauthorized by the Contract Administrator) **-** "Morbid Obesity" means body weight is twice the ideal body weight (IBW) as determined by standard accepted national tables or 100 pounds over the IBW, or body mass index (BMI) value of greater than 40.

Charges for surgical and non-surgical morbid obesity treatment **must be preauthorized by the Contract Administrator** and is subject to all of the following guidelines:

a. Only eligible charges incurred by a **Network Provider** are covered.

b. The patient's body weight is twice the ideal body weight (IBW) as determined by standard accepted national tables or 100 pounds over the IBW, or body mass index (BMI) value of greater than 40.

c. The patient has a health problem which is related to the obesity and which may ultimately be life threatening (such as severe hypertension, sleep apnea, congestive heart disease, or insulin dependent diabetes).

Non-surgical weight loss treatment of morbid obesity is covered with respect to physician office visits, prescribed diet medication, and consultations with a registered licensed dietitian regarding eating education. Items such as weight loss instructions or memberships from commercial weight loss programs; exercise programs or activities or equipment; over-the-counter-drugs or appetite suppressants; or books would not be covered.

Gastric restrictive or surgical procedures for morbid obesity are covered subject to the additional following provisions:

a. One surgical procedure per lifetime while on a County medical plan. This procedure is specific to gastric restrictive or surgical procedures for morbid obesity.

b. A medical review service used by the Plan determines that the surgery meets the following criteria:

   (1) Patient has at least six (6) months of repeated and well documented weight loss efforts that have failed within the last two (2) years. Such weight loss efforts must be in a structured or physician-supervised programs that are medically balanced and safe. As an example, the patient should have been through at least six (6) months of documented efforts in structured weight loss programs (including counseling) which have resulted in no weight loss or minimal weight loss with at least an 80% attendance record.

   (2) Absence of medical co-morbidity that makes surgical intervention too risky or hazardous.

   (3) The surgical facility and physician performing the procedure has substantial experience with surgical treatment of obesity, is willing to provide (upon request) documented outcomes and provides an appropriate aftercare program for medical management and counseling. The program should include treatment for nutritional and psychiatric counseling as part of a multi-disciplinary approach to treating patients being considered for surgery and for patients post surgery.

   (4) The patient must have full understand and acceptance (through written acknowledgment) of the high risks associated with gastric restrictive surgery, that the surgery itself may not be a long term solution for weight loss, and the surgery may result in other potentially serious medical complications.

Due to the extreme nature of this surgical procedure and the high risk of complications, a second surgical opinion is required from a physician who performs bariatric surgery, as to the necessity of the surgery, the type of surgery to be performed and the place performed as to being able to handle any complications that may arise.

Newborn Charges - Newborn services which include the initial hospital confinement charges, Physician hospital charges and physician charges for circumcision (whether inpatient or outpatient). Charges for Routine Newborn Nursery Care is care while the newborn in Hospital-confined after the birth and includes room, board and other normal care for which a Hospital makes a charge. Routine newborn care is limited to a maximum of four (4) days. Charges for covered routine nursery care will be applied toward the Plan of the newborn child if billed separately from the mother.

Orthotics - Only in lieu of surgery, the initial purchase, fitting and repair of orthotic appliances such as braces, splints or other appliances, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness.

Oxygen - Oxygen and/or rental of equipment required for its administration.

Professional Services - Professional Services by;

a. A physician;

b. A physician's assistant when supervised by a physician as defined herein;

   1. Eligible Expenses from a Physician Assistants (P.A.) performing assistant surgery, while working under the direct supervision of a surgeon (expenses are limited to 25% of the allowable for the primary physician charges and are payable according to the network status of the primary physician).

   2. Eligible expenses from a Physician Assistants (P.A.) while working under the direct supervision of a physician in an office setting (100% of the allowable for the primary physician charges is eligible and expenses are payable according to the network status of the primary physician).

c. An assistant surgeon (expenses limited to 25% of the allowable for the primary physician charges);

d. A nurse, that are non-custodial;

e. An anesthetist or anesthesiologist;

f. A licensed physical therapist for restoratory or rehabilitory physical therapy for loss or impairment of function due to an illness or trauma, or congenital defects for which surgery has been performed, subject to the maximum stated in the schedule of benefits;

g. A Doctor of Chiropractic for the detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for the removal of nerve interference where such interference is the result of or related to distortion misalignment or subluxation of or in the vertebral column, limited to a Calendar Year Maximum Benefit stated in the Schedule of Benefits of this document;

h. A licensed occupational therapist for restoratory and rehabilitory occupational therapy for loss or impairment of function of an upper extremity due to an acute illness or trauma, or congenital defects for which surgery has been performed, subject to the maximum stated in the schedule of benefits;

i. A licensed speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to an illness or trauma, or congenital defects for which surgery has been performed provided such loss or impairment is not due to a functional nervous disorder, subject to the maximum stated in the schedule of benefits;

j. A certified nurse midwife;

k. A pathologist;

l. A radiologist;

m. A Registered Nurse First Assistants (RFNA) while working under the direct supervision of a physician (expenses are limited to 25% of the allowable for the primary physician charges and are payable according to the network status of the primary physician);

n. Masters' level Psychotherapists who hold the certification of LMSW (Licensed Masters in Social Work) or LPC (Licensed Professional Counselor) and are eligible for membership in his/her respective society or association.

o. A Registered Respiratory Therapist (R.R.T.) charges when specifically prescribed by a physician as to type and duration but only to the extent that the therapy is for improvement of bodily function.

Preventive Care Benefit - Eligible expenses for preventive care benefits for all Covered Persons as outlined in the Schedule of Benefits. Covered items shall include, but are not limited to, physical exams or check-ups, immunizations, pap smears, mammograms and prostate exams.

Prosthetics - Initial artificial limbs or eyes, if prescribed by an M.D. or D.O., or other prosthetic appliances to replace lost physical organs or parts if the loss occurred while covered under this Plan. Also includes, replacement of prosthetic appliance if necessitated by bodily change or medical necessity and charges for repair and/or adjustments, when medically necessary.

Reconstructive Surgery - Charges for Reconstructive Surgery due to:

a. an illness, such as breast cancer (e.g. reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications at all stages of mastectomy, including lymphedemas); or

b. a congenital birth defect, with Pre-Authorization by the Contract Administrator.

Rhinoplasties and Blepharoplasties - For rhinoplasties and blepharoplasties, with pre-authorization by the Contract Administrator, to correct a functional condition after a Covered Person's coverage has been in effect for at least twelve (12) months or in the case of a rhinoplasty, to correct an accidental injury as provided herein.

Second Opinions - Second and third surgical opinions. The second opinion must be given by a board certified internist or a board certified specialist who is not financially associated or affiliated with the surgeon performing the surgery.

Serious Mental Illness – Please see "Mental/Nervous Disorders and Substance Abuse".

Sleep Disorders (Limited to a Lifetime Maximum Benefit as stated in the Schedule of Benefits) **-** Charges for the initial diagnoses are covered; however, other expenses incurred for treatment after the initial testing are only eligible expenses if there is a medical diagnoses subject to the limitations in the Schedule of Benefits.

Sterilization - Eligible expenses for voluntary sterilization such as tubal ligations and vasectomies.

Transplants (Tissue) – Tissue transplants such as bones, tendons, cornea, skin, heart valves, nerves and veins. Coverage for organ transplants are provided under a separate policy.

Vitamins - Charges for Pre-Natal vitamins must be prescribed by a physician and are covered under the Prescription Drug Plan. Charges for any other vitamins only when documented as medically necessary to sustain life and approved by the Contract Administrator.

X-rays - Charges for X-rays, radium and radioactive isotope therapy, cobalt and chemotherapy.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

Abortions - Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term. NOTE: Complications arising out of an abortion are covered as any other Sickness.

Acupuncture - Charges incurred in connection with oriental pain control (acupuncture or acupressure) unless administered by an M.D. or a D.O.:

Behavior Modification - Charges for sex therapy, hypnotics training (including hypnosis), any behavior modification therapy including biofeedback, educational testing and therapy (including therapy intended to improve motor skill development delays) or social services.

Centers for Medicaid and Medicare Services - If treatment is not stated as a covered item under the Centers for Medicaid and Medicare Services (CMS) guidelines or as a covered item under Covered Expenses then it is not a covered expense under the Plan.

Chelation Therapy - Charges in relation to Chelation Therapy unless for heavy metal poisoning.

Complications of Non-Covered Treatments - Services rendered as a result of (or due to complications resulting from) any surgery, services, treatments or supplies specifically excluded from coverage under this Plan, except as noted herein.

Cosmetic Surgery - Incurred in connection with cosmetic surgery to improve appearance, rather than to correct a functional disorder; here, functional disorders do not include mental or emotional distress related to a physical condition. For rhinoplasty, blepharoplasty, or brow lift due to a non-functional condition.

Custodial Care - Services or supplies provided mainly for custodial care or maintenance care.

Dental Care - Charges for dental care or treatment to the teeth, aveolar processes, gingival tissue, osseous surgery or for malocclusion, unless otherwise stated under Covered Medical Expenses.

Donor - For medical expenses incurred by a donor for a transplant/tissue procedure (whether covered by this Plan or not).

Drugs - Even if prescribed by a physician, which are:

1. not approved for sale in the United States; or
2. over-the-counter drugs (i.e. nutritional or dietary supplements); or
3. outpatient prescription drugs not purchased through the Prescription Drug Program; or
4. not approved by the Food and Drug Administration (FDA).

Educational or Vocational Testing - Services for educational or vocational evaluation, rehabilitation, or retraining.

Excess Charges - The part of an expense for care, treatment, and/or services that is in excess of the Maximum Eligible Charge.

Exercise Equipment or Programs - Exercising equipment (even if prescribed by a physician), vibratory equipment, swimming or therapy pools, massage therapy, recreational therapy, enrollment in health or athletic clubs. This does not include Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or not Medically Necessary - Charges for investigational or experimental treatment or when not medically necessary for diagnosis or treatment of an illness or injury.

Extended Skilled Nursing Home - Care or treatment in an extended skilled nursing home, except as defined herein.

Eye Care - Charges for eyeglasses, contact lenses, or for non-routine orthoptics, vision therapy, or other social vision procedures including but not limited to radial keratotomy (RK) and Laser Assisted Intrastromal Keratomileusis (LASIK) for correction of vision. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Foot Care - Incurred for the treatment of corns, calluses, or toenails, unless the services are to perform a partial or complete matrixectomy due to infection or debridement of these areas damaged by metabolic or peripheral vascular disease.

Foreign Travel - Services, supplies, care or treatment out of the U.S. if travel is for the sole purpose of obtaining medical services.

Genetic Counseling or Testing - Charges incurred in connection with genetic counseling or testing.

Government Coverage - For care or treatment which an Employee is not financially responsible for that is provided or furnished by a hospital operated by a government unit, or the Government of any country; or any agency thereof, except as provided by Federal law.

Growth Hormone Deficiency - For treatment related to growth hormone deficiency;

Habit Breaking - For services and supplies furnished for the purpose of breaking a "habit", including but not limited to overeating, smoking (including patches), or thumb sucking.

Hair Loss - Services, supplies, care or treatment for hair loss including wigs, hair transplants or any medication that promises hair growth, whether or not prescribed by a physician, except for wigs after chemotherapy.

Hearing Aids and Exams - Charges for services or supplies in connection with hearing aids, exams for their fitting or repair of, except as specifically listed under Eligible Medical Expenses.

Home Health Care Expenses - Expenses that are for:

1. Custodial care; or
2. Transportation services; or
3. Any period during which the Covered Person is not under the continuing care of a Physician.

Hormonal Disorder - Charges for hormonal disorder, male or female, resulting in a treatment program of periodic rapid assays of reproductive hormones (e.g., estradiol, luteinizing hormone, Follicle Stimulating Hormone (FSH), progesterone and androgens); gonadotropin stimulation given in a sequential manner requiring laboratory tests to evaluate the following gonadotropin stimulation; and follow-up office visits, not including diagnoses of menopausal disorders.

Hospital Employees - Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal Acts - For any condition, disability, or expense resulting from or sustained as a result of being engaged in an illegal occupation, commission of, or attempted commission of an assault or a criminal act.

Impotence - Supplies, services, care or treatment (including medications or prescriptions) in connection with treatment for impotence.

Infertility - Services, supplies, care or treatment in connection with infertility, infertility studies, invitro fertilization or embryo transfer, artificial insemination, or any surgical procedure for the inducement of pregnancy which involves either a Covered Person or a surrogate acting as a donor or a recipient.

Learning Disability - Charges related to treatment of a learning disability unless the disability is medically related;

Marriage Counseling - Charges for marriage counseling, or family counseling when there is not an identified patient.

Massage Therapy - Charges for massage therapy or rolfing;

No Charge - Services, supplies, care or treatment that a Covered Person is not financially responsible for or are only made because medical coverage exists.

Non-emergency Hospital Admissions - Hospital admission for diagnostic or evaluation procedures unless the tests could not be performed on an outpatient basis without adversely affecting the health of the patient. Hospital room and board charges for admission the night before surgery unless it is medically necessary.

No Obligation to Pay - Charges incurred for which the Plan has no legal obligation to pay.

No Physician Recommendation - Services, supplies, care of treatment for which the person on whose behalf a claim is presented is not under the regular care of a physician. Also including care or treatment provided by:

1. Christian Science Practitioner; or
2. Homeopath; or
3. Marriage, Family, Child Counselor (MFCC);or
4. Naturopath.

Not Specified as Covered - Any service unless otherwise stated under Covered Medical Expenses.

Obesity - For services, treatment or supplies (including charges for vitamins, food, nutritional supplements, exercise equipment or health club membership) rendered to any participant for treatment of obesity or for weight reduction (including weight loss programs).

Occupational - For any condition or disability which would entitle the Covered Person to any benefit under Workers' Compensation or similar legislation.

Orthotics - Incurred for orthopedic or corrective shoes and supportive appliances for the feet.

Personal Comfort Items - For air conditioners, humidifiers, dehumidifiers and purifiers, swimming pools, hot tubs, or waterbeds, whether or not prescribed by a physician.

Plan Design Excludes - Charges for services, supplies, care or treatment excluded by the Plan design as mentioned in this document.

Pregnancy of Dependent Daughter - Charges for the pregnancy, childbirth, miscarriage, or complications of a pregnancy incurred by Dependent Child(ren).

Private Duty Nursing - Charges made by a nurse for services, which can be performed by a person who does not have the skill and training of a nurse.

Relative Provided Services - For professional services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person whether such relationship is by blood or exists in law.

Self-Inflicted - Services, supplies, care or treatment resulting from a voluntarily self-inflicted injury or attempted voluntary self-destruction while sane or insane. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Services Before or After Coverage - For injury or sickness sustained while the person is not covered hereunder.

Sex Changes - For sex change and/or treatment for transsexual purposes or treatment for sexual dysfunctions of inadequacy which includes implants and drug therapy.

Surgical Sterilization Reversal - For surgical procedures to reverse sterilization.

TMJ - For the treatment of TMJ (temporomandibular joint syndrome, including orthodontics);

Transplants (Organ) – Coverage for organ transplants is provided under a separate arrangement.

Travel or Accommodation - For transportation or travel other than emergency transportation service by professional ambulance as stated in the Covered Medical Expenses.

Vitamins - For vitamins, nutritional and dietary supplements even if prescribed by a physician.

War - For any condition, disability, or expense resulting from or sustained as a result of war or act of war, declared or undeclared.

DENTAL BENEFIT SUMMARY

SCHEDULE OF DENTAL CARE BENEFITS

Benefits for Eligible Dental Care Expenses are provided based on the schedule presented below:

DEDUCTIBLE
$50 per person per calendar year, up to a maximum of $150 per family

BENEFITS FOR ELIGIBLE EXPENSES	
Preventive Services	100% of eligible expenses incurred; the calendar year deductible does not apply.
Basic Services	80% of eligible expenses incurred, after the calendar year deductible is satisfied.
Major Restorative Services	50% of eligible expenses incurred, after the calendar year deductible is satisfied.
Orthodontia Services	50% of eligible expenses incurred, the calendar year deductible does not apply.

MAXIMUM BENEFIT	
Preventive, Basic and Major Services	$2,000 per person per calendar year
Orthodontic Services	$1,500 per person per lifetime

ELIGIBLE DENTAL CARE EXPENSES

A charge for any of the services or supplies listed below will be considered eligible if it is reasonably necessary for the care of your or your dependent's dental condition. To be considered reasonably necessary, the service or supply must be ordered by a dentist licensed by his or her state of practice and must be commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed dental condition. The service or supply must not be educational or experimental in nature, nor provided primarily for the purpose of dental or other research.

In addition to the above definition of the term "Eligible Expense", the following terms have the defined meaning as used in this Plan:

a "dental hygienist*"* means a person who is licensed by the state in which services are performed to practice dental hygiene and who works under the supervision and direction of a dentist; and

a "dentist" means a person licensed by his state of practice to practice dentistry and render dental care services within the scope of his license for treatments covered under the Plan.

Dental Expenses are deemed to be incurred on the date on which the service or supply is rendered or obtained except as follows:

1. With respect to a fixed partial denture, crown, inlay or onlay, on the first date of preparation of the tooth or teeth involved; or

2. With respect to an appliance, including modification of the appliance, on the date the first impression is made; or

3. With respect to root canal therapy, on the date the pulp chamber is opened; or

4. With respect to orthodontic procedures, on a monthly basis in the following manner:

    a. For initial appliances - commencing on the first date treatment is provided;

b. For all other charges – the same date of each subsequent month during the continuance of such treatment. The Plan will consider in equal Monthly amounts the remaining 75% of the Maximum Eligible Charge amount of the entire fee. Such Monthly amounts will cease on the date the Covered Person's benefits terminate.

Preventive Services

Routine oral examinations and prophylaxis – Limited to two (2) per Calendar Year. Includes periodontal cleaning in the absence of conditions of curettage, flap surgery, gingivectomy or osseous surgery.

Diagnostic x-rays - bitewings are limited to two (2) per Calendar Year. Full-mouth x-rays are limited to no more than one during any consecutive 36-month period. All other x-rays required for diagnosis or treatment of a dental condition will be eligible without frequency limitations.

Topical fluoride applications – Limited to two (2) per Calendar Year. Limited to Covered Persons under age 19.

Space maintainers – limited to the initial appliance. Includes installation, fitting, and all adjustments. Limited to Covered Persons under age 19.

Emergency treatment to relieve pain - but only in response to injury or sudden development of dental pain, and only when the treatment is not on the same day as any other service except x-rays.

Tests and laboratory examinations – includes bacteriologic cultures, pulp vitality tests and diagnostic casts (study models).

Basic Services

Oral surgery – including postoperative treatment, for:

- extraction of one or more teeth (including erupted wisdom teeth);
- alveoplasty, alveolectomy, frenulectomy, stomatoplasty, excision of pericorneal gingiva, exostosis, hyperplastic tissue and oral tissue for biopsy and tooth replantation;
- any other oral surgery involving any tooth structure, alveolar process or gingival tissue, except excision of a tumor or cyst or incision and drainage of an abscess or cyst.

Periodontal treatment or surgery - to remove diseased gum tissue or bone. Periodontal cleanings are limited to two (2) per Calendar Year.

Root canals, root canal fillings and other endodontic treatment.

Amalgam, silicate, acrylic, synthetic porcelain and composite fillings

Stainless steel crowns

Major Services

Gold restorations, crowns, inlays and onlays - provided the tooth cannot be restored by a filling material, and replacement of same, provided the existing prosthesis is no longer serviceable and at least five years have elapsed since the initial placement, or replacement is needed because of Injury.

Fixed bridgework, partial or full dentures - but only to replace natural teeth (excluding third molars) that are extracted while covered under the Plan. Eligible expenses include adjustments during the first 6-month period after placement.

Addition of teeth to an existing fixed bridge, partial or full denture - but only to replace teeth that are extracted while covered under the Plan.

Replacement of an existing fixed bridge with a new bridge - or replacement of an existing full denture with a new denture, provided:

a. the replacement is needed to replace teeth that are extracted while covered under the Plan;
b. the existing denture or bridgework is certified by a Dentist to be at least 5 years old at the time of replacement and cannot be repaired; or,
c. the existing denture is certified by a Dentist to be an immediate temporary full denture that cannot be made permanent and is replaced with a permanent denture within 12 months of the date is was installed.

Repair and recementing of crowns, inlays, onlays, fixed or removable dentures – or relining or rebasing of old dentures more than six months after installation of an initial or replacement denture, limited to one relining or rebasing during any thirty-six consecutive month period.

Orthodontia Services

Expenses eligible under the Plan are charges by a dentist or orthodontist for treatment, material and supplies furnished in connection with orthodontic treatment. There is no age limit for orthodontia services. Charges for orthodontic procedures are considered to be incurred on a monthly basis, commencing for the initial appliances on the first day treatment is given and on an arrears basis for all other charges provided the child remains continuously covered during the course of treatment.

Services and supplies include:

initial consultation, models, X-rays and other diagnostic services;

the initial banding or placement of a fixed or removable orthodontic appliance;

periodic adjustments; and

retainers.

Space maintainers are not covered as an orthodontia expense.

DENTAL CARE EXCLUSIONS

Except as specifically stated otherwise, no benefits are payable under the Plan for the following expenses.

Above MEC – Any charges in excess of the Maximum Eligible Charge of the least expensive alternate service or material consistent with adequate dental care, when such alternate services or materials are customarily provided. For charges that are not eligible or portions of charges that exceed the Maximum Eligible Charge.

Appointments Not Kept - Charges for appointments not kept, or for completion of claim forms.

Cosmetic - Dental care which is provided solely for the purpose of improving appearance, including charges for veneers, personalization or characterization of dentures and precision attachments when form and function of the teeth are satisfactory and no pathological condition exists.

Coverage Not in Force - Charges for a crown unless the tooth is prepared (drilled or filed) for the crown while the covered person's Dental Coverage is in force.

Covered Under Another Plan - Charges for services which are payable under the Group Medical Plan or any other group hospital, surgical, or medical coverage.

Dentist or Doctor Not Licensed - For treatments not prescribed or performed by a licensed dentist or doctor.

Does Not Meet ADA Standards - Dental care which does not meet the standards of dental practice accepted by the American Dental Association.

Educational Purposes - For education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene, or dental plaque control.

Family Members - Dental care or treatment when rendered to insured persons by spouses, children, brothers, sisters, parents, or similar family members of such persons' spouses.

HMO - Dental care which is provided by a Health Maintenance Organization or similar organization.

Hospital Charges

Implantology - For implantology, including implants and appliances constructed in association therewith, and the surgical removal of implants; and for other procedures, services, or supplies that are experimental in nature.

Lost or Stolen - For the replacement of a lost, missing, stolen, or duplicate prosthetic device, or other dental appliance.

No Requirement to Pay - Dental care which is furnished while a person is confined in a hospital operated by the United States Government or any agency thereof, or dental care for which the person would not be required to pay if there were no insurance. For services or supplies for which there would be no charge in the absence of this coverage.

Not Furnished by a Dentist or Doctor - For anything not furnished by a dentist or physician as defined in this Plan, except x-rays ordered by a dentist and services of a licensed dental hygienist under a dentist's supervision.

Not Listed as an Eligible Expense - Dental care not included in the list of defined eligible expenses.

Prior to Coverage - Charges for any work in progress prior to the Covered Person’s effective date under this Plan.

Root Canals Not Begun Wile Covered - Charges for root canal therapy unless therapy begins on that particular tooth while the covered person's Dental Coverage is in force.

Sealants - For sealants.

Temporomandibular Joint Dysfunction

Sport or Home Use - Expenses related to services or supplies of the type normally intended for sport or home use.

War or Workers Compensation - Charges with respect to any dental care directly or indirectly due to or resulting from:

a. War, insurrection, or the hostile action of the armed forces of any country;

b. Any cause for which indemnity or compensation is provided under any Workers' Compensation Law or similar legislation.

LIMITATION OF DENTAL COVERAGE/PRE-TREATMENT ESTIMATE OF BENEFITS

The Plan will consider eligible expenses based on the appropriate treatment necessary to eliminate oral disease or to replace missing teeth. For example, if a tooth can effectively be restored with amalgam filling but a Covered Person elects to crown the tooth, the Plan will consider its benefits based on the Maximum Eligible Charge limit for the amalgam filling. The Covered Person will be responsible for paying the remaining charges.

In addition, temporary services will be considered as an integral part of the final service rather than as a separate service. The allowance for both the temporary and permanent procedures may not exceed the Maximum Eligible Charge limit of the permanent procedure.

If a dentist recommends a course of treatment that is expected to exceed $300, a Covered Person may obtain a pre-treatment estimate of your benefits. To obtain a pre-treatment estimate of benefits, the dentist should submit his or her treatment plan to the Contract Administrator, showing the recommended course of treatment. The Contract Administrator will review the treatment plan and advise the Covered Person and his dentist of the amount payable based on the Schedule of Benefits. A pre-treatment estimate of benefits is not a guarantee of payment.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

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

group, blanket or franchise coverage provided through HMOs and other prepayment group or individual practice plans;

governmental programs, as permitted by law;

any coverage under labor-management trusted plans, union welfare plans, employer organization plans or employee benefit organization plans; or

any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits, which would have been paid or payable if a claim had been properly made for them.

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.

If a Covered Person is entitled to Medicare Part A and B, benefits under This Plan will be reduced by the amount of benefits the Covered Person would have received had they enrolled in Medicare.

This Plan - The coverages of this Plan.

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. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the lesser of those amounts shall be the Allowable Expense for This Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, 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 under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

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 or payable 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 or payable by the Other Plan(s).

When This Plan's PPO negotiates a specific COB provision with a particular participating provider, the PPO's COB provision supersedes the Plan's normal COB provisions.

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.

Medicare as an "Other Plan" - Medicare 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, member, 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 that the plan covering the person as an employee, member, 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 or are not separated (whether or not they have ever been married), or (2) 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 have ever 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.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. 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 under This Plan 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 under This Plan. 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 under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the 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, THIRD PARTY RECOVERY

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's 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 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 Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary 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 Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary 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 Plan Beneficiary agrees to subrogate the Plan to 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 Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

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

then the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any 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 Plan Beneficiary 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 subrogation lien. The obligation 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 Plan Beneficiary'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 Plan Beneficiary, 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 Plan Beneficiary.

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. The Plan's benefits shall be excess to:

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

Wrongful Death Claims

In the event that the Plan Beneficiary 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 Plan Beneficiary's obligation:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
b) to provide the Plan with pertinent information regarding the sickness, disease, disability or injury, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary 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 Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset

Failure by the Plan Beneficiary 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 may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary 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 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

Eligibility Requirements - Employees
To participate in the Plan coverages which are described herein, an Employee must be in active employment for the Employer, in permanent status (as defined by 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). The term "Employee" shall include Elected Officials of the County.

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 on which 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.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

NOTE: An eligible Employee does <u>not</u> include one who is eligible for Medicare by reason of age and who has elected Medicare coverage in lieu of Plan coverage.

Retirees are eligible for coverage under the Plan provided the Retiree makes an election to continue under the Plan on or before his last day of employment. A Retiree's dependents may be covered under the Plan provided the Retiree elects coverage for such dependents prior to the Retiree's last day of employment, and the dependents qualify as dependents under the Plan. Retirees cannot add dependents after their last day of employment. The term "Employee" shall be understood to include the term "Retiree", except where the context indicates otherwise.

Effective Date - Employees
An Employee's coverage is effective, subject to timely enrollment, on the first day following ninety (90) days of full-time or permanent employment with the Employer (known as the "waiting period").

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can only 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 legal spouse. The marriage must meet all requirements of a valid marriage contract in the Employee's state of residence;

- a child under age 26. For these purposes a "child" will include a natural child, stepchild, a child who is in the Employee's legal custody, or a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends.

It shall also include, notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Qualified Domestic Relations order (QDRO) or 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.

A Dependent child who no longer meets the Dependent child eligibility requirements may again become eligible for coverage once he meets the Plan definition of a Dependent.

Dependent Verification
Prior to adding a new dependent to the Plan, proper documentation verifying the dependent's eligibility is required. Please see your Benefit Administrator for a list of the acceptable documentation for enrolling a dependent spouse or child.

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution or divorce;

a spouse who is eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage;

any person who is on active duty in a military service, to the extent permitted by law;

any child who, at any time during the eligibility period, becomes married. Such child can regain eligible status if divorced or legally separated;

any child who is covered under the Plan as a Dependent of another Employee.

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

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

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 and other circumstances can allow a Dependent to be enrolled). Otherwise, a Dependent will be considered a "Late Enrollee" and 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
An individual who enrolls in accordance with this "Special Enrollment Rights" provision is not a "late enrollee".

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 under the Plan 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 such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and 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;

- 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 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;

- loss of Medicaid coverage.

and the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day following the loss of coverage.

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

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 Plan 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 date of marriage;

where acquisition of a child 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). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Change in Status, Cost or Coverage – An Employee will be permitted to make Plan election changes when such changes are consistent with and made concurrently with changes allowed under the Plan Sponsor's Section 125 cafeteria plan due to a qualified change as permitted under Federal law. The effective date of the Plan changes will be concurrent with the effective date of the cafeteria plan changes, unless an earlier effective date would be allowed under the terms of one of the other subsections of this "Special Enrollment Rights" provision.

Newborn Children – Enrollment Requirements
For coverage to begin on the newborn's date of birth, the Employee must enroll the child within thirty-one (31) days from the newborn's date of birth. If enrollment is not made within thirty-one (31) days, such child is not eligible for coverage until the next annual enrollment period.

NOTE: During the limited 31-day benefit period, a newborn 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 newborn 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
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 annually. Plan coverage will be effective on January 1st following the end of the Open Enrollment period

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

Reinstatement / Rehire
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 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). 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 under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan 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.

Restatement / Replacement of Benefits
This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan;

termination of participation in the Plan by the Employee;

the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information;

the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

the last day of the month in which the covered Employee retires (unless Retiree coverage is elected), leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision;

the date the Employee dies.

NOTES: 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.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination
A Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

the last day of the month in which the dependent reaches the maximum age of 26;

the date on which the Dependent ceases to meet the eligibility requirements of the Plan, 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). However, 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 replacement coverage which will take effect immediately upon termination.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

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

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date 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.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children
If an already covered Dependent child attains age 19 or 25, which would otherwise terminate his status as a "Dependent", and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained age 19 and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Contract Administrator within thirty-one (31) days of the child's attainment of the limiting age. The Contract Administrator, on behalf of the Plan Sponsor, shall have the right to require satisfactory proof of continuance of such incapacity, inquire into changes in marital status, and to examine the Dependent, but not more than once a year.

A Dependent's extended coverage hereunder will terminate upon the occurrence of: (1) a failure to submit any required proof of incapacity, (2) a failure to permit an examination, (3) the child ceasing to be incapacitated, or (4) the child's marriage.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in eligible active status 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. Only newly acquired Dependents may be added during a leave of absence period. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that 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 into the Plan by reference;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of this Plan.

NOTE: 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. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her duties).

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.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months (or up to 24 months for elections made on or after December 10, 2004), or the duration of active military service, whichever is shorter. The Employee must pay the cost of coverage. The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost if the military leave is less than 31 days.

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.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

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

When coverage under the Plan 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.

The Employee who is ordered to active military service (and that 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 above stipulations.

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

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, which 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.

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 child of a 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 within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse 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 which 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 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 or her Medicare coverage is in effect. In accordance with IRS Revenue Ruling 2004-22, it is not the Plan's intent to recognize a terminated Employee's Medicare entitlement as a second Qualifying Event for a spouse or child who is covered under the Plan as a COBRA Qualified Beneficiary;

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

for an Employee's spouse 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).

Non-COBRA 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 – 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, etc.), 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 in the Plan's Summary Plan Description (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. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. 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 which allow Non-COBRA 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 Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA 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 is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 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. If payment is not made within such time period, the COBRA election is null and void. The initial premium 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. 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 during the Plan's 12-month determination period if:

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

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which 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) which results in a different coverage cost.

Timely payments which 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 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 Qualifying Event.

If a Qualifying Event occurs which 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.

Also, COBRA coverage will run concurrently with medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). That is, if an Employee on military leave continues coverage under USERRA, equivalent months of COBRA entitlement will be exhausted, unless there was another Qualifying Event.

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 which 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 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 pre-existing 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 Non-COBRA 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, federal income tax filings, etc. 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 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 pre-existing 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(b), 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.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that 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 that 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. A claim must be in English. Any request for a benefit determination that is in a language other than English will not be considered a claim for the purposes of the Plan. The claimant is responsible for any and all costs associated with translation. Such translation must be obtained by the claimant prior to submission of a request for benefit determination.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

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

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the Utilization Management Program section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on 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 365 days after charges are incurred. Upon termination of the Plan, final claims must be received within ninety (90) day of termination.

   A Post-Service Claim should be submitted to:

   Boon-Chapman Benefit Administrators
   P.O. Box 9201
   Austin, TX 78766-9201
   Electronic Claim Submission: Payer ID# 74238

   For status, please call Boon-Chapman at (800) 252-9653.

   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.

It is the Claimant's obligation:

1) to cooperate with the Plan, or any representatives of the Plan, in handling claims;
2) to provide the Plan with pertinent information regarding the sickness, disease, disability or injury and any other requested additional information relating to the claim;
3) to take such action and provide such information as the Plan may require to process a claim.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan 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 under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

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

CLAIMS TIME LIMITS AND ALLOWANCES

The following chart sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond, etc.). It is the Claimant's obligation to:

a) cooperate with the Plan, or any representatives of the Plan, in handling claims;
b) provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, and any other requested additional information relating to the claim;
c) take such action and provide such information as the Plan may require to process a claim.

Important: These claims procedures 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.

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Urgent Claim - defined below	
Claimant Makes Initial <u>Incomplete</u> Claim Request	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. Claimant will have a reasonable period of time, but not less than 48 hours, to provide the required information to complete the claim.
Plan Receives <u>Completing</u> Information	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. Oral notice can be given in addition to written or electronic notice. Written or

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
	electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.
Claimant Makes Initial Complete Claim Request	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. Oral notice can be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.

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. All necessary information, including the Plan's handling of an appeal, shall be transmitted between the Plan and the Claimant by telephone, fax or other available and similarly expeditious methods.

Whether a claim is urgent will generally be decided by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician familiar with the Claimant's condition decides that the claim involves urgent care, the Plan must defer to the Physician's judgment.

NOTE: The benefit determination time frame stated above shall begin at a time a claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

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.

Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before 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.
Claimant Requests Extension for Urgent Care	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. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.

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.

Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
	to complete the claim request. Claimant may request a written notification. Claimant has at least 45 days from receipt of such notice to provide the required information.
Plan Receives Completing Information	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
Claimant Makes Initial Complete Claim Request	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.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).

"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.

In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.

"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant – see definition of "full notice" below. Claimant has at least 45 days to provide required information.
Plan Receives Completing Information	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.
Claimant Makes Initial Complete Claim Request	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.
Claimant Appeals	See "Appeals Procedures" subsection.
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.

In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the

claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.

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. 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;

the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

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.

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 (comments, documents, records, etc.) 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: The Plan requires two (2) levels of mandatory appeal.

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 any medical or vocational experts whose advice was obtained in connection with the claim denial;

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 and the Claimant's right to obtain the information about such procedures.

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.

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 under the Plan.

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

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information.

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 under the Plan 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 including, but not limited to a/an:

Audiologist
Certified or Registered Nurse Midwife – if under the direction of an obstetrician
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Clinical Social Worker – Advanced Clinical Practitioner (CSW-ACP)
Dentist (DDS or DMD)
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Dietician (LD) and Provisional Licensed Dietician (PLD)
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatrist (MD)
Registered Nurse (RN)
Respiratory Therapist
Speech & Hearing Therapist
Speech Pathologist

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

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;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities;

blood banks;

speech and hearing centers;

ambulance companies.

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**;

any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services;

a Christian Science Practitioner;

a Doctor of Dietary Medicine (DDM)

a Marriage and Family Therapist (MFT);

a masseur or masseuse, a naturopath, a physical culturist, physical education instructor or a Rolfer.

Dependent - see **Eligibility and Effective Dates** section

Dialysis Services means any service, supply, equipment or drug utilized in connection with hemodialysis or peritoneal dialysis.

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

Emergency - see "Medical Emergency"

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 Fiduciary of the Plan is any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

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 its 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 or **Hospice Agency** - 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 meets fully all of the following tests:

it is primarily and continuously engaged in providing, for compensation from its patients and on an Inpatient basis, medical, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

it continuously provides 24-hour-a-day nursing service by a registered nurse (RN);

it is not, other than incidentally: (1) a place for convalescence, rest, or nursing services, (2) a facility primarily affording custodial, educational, or rehabilitory care, (3) a facility for the aged, drug addicts, or alcoholics, (4) any military or veteran's hospital or any hospital contracted for or operated by a national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where the Covered Person is legally obligated to pay; and

is an institution operated pursuant to law and accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals.

A Hospital also includes a chemical dependency treatment center, psychiatric hospital, or rehabilitative hospital provided the institution meets all of the following tests and is operated primarily for the purpose of providing the specialized care and treatment for which it is duly licensed:

it provides 24-hour nursing services under the supervision of a Physician or a registered nurse (RN);

it maintains daily clinical records on each patient and has available the services of a Physician under an established agreement;

it provides appropriate methods of dispensing and administering drugs and medicines; and

it has a transfer arrangement with one or more Hospitals as defined, a utilization review plan in effect, and treatment policies developed with the advice of and reviewed by a professional group who are specialists in the care and treatment rendered by such facility.

NOTE: A "Hospital" does <u>not</u> include a Christian Scientist Hospital or facility.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (Hospital, 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), 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.

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

<u>Maximum Eligible Charge (MEC)</u> is an amount determined in the discretion of the Plan Administrator or its delegate using any one of the following:

- A fee that was negotiated with the Provider;
- A fee determined using a national relative value scale;
- A fee determined using a percentage of what Medicare would allow for the service or supply;

- A fee determined using an industry accepted fee database; or
- A fee determined using a percentage off billed charges.

With regard to charges made by a provider of service participating in the Plan's Preferred Provider Organization (PPO), "Maximum Eligible Charge" shall mean the rates negotiated between the PPO and the participating providers.

Maximum Eligible Charge for Outpatient Dialysis Services provided in connection with the first 40 dialysis treatments while a Covered Person is covered by the Plan as determined in the discretion of the Plan Administrator or its delegate, is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. A fee determined using a commercial healthcare database;

The Maximum Eligible Charge for Outpatient Dialysis Services thereafter, is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. 125% of what Medicare would allow.

With regard to charges made by a provider of service participating in the Plan's PPO program, "Maximum Eligible Charge" shall mean the rates negotiated between the preferred provider organization and the participating providers unless services have otherwise been specifically excluded from the PPO reimbursement arrangement in the schedule of benefits.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medically Necessary - When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

be rendered in connection with an Injury or Illness;

be consistent with the diagnosis and treatment of your condition; and

be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate. Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

it is provided only as a convenience to the Covered Person or provider;

it is not appropriate treatment for the Covered Person's diagnosis or symptoms;

it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or

it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;

is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or

is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

The sources of information to be relied upon are:

the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;

a Covered Person's medical records;

protocol pursuant to which the treatments is to be delivered; or

any regulations and publications set forth by any governmental agency.

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 benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, 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.

Preferred Provider Organization (PPO) - A health care organization composed of physicians, hospitals, or other providers which provides health care services at a reduced (contracted) rate.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising there from. See “Pregnancy Care” in the list of **Eligible Medical Expenses** for further information.

Rehabilitation Center – see "Hospital"

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 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Sickness will mean bodily illness or disease (other than mental health conditions), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Substance Abuse Treatment Center - A facility that provides a program for the treatment of substance abuse pursuant to a written treatment plan approved and monitored by an MD or DO and which facility is also:

affiliated with a Hospital under a contractual agreement with an established system for patient referral;

is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;

licensed as a substance abuse treatment program by the Texas Commission on Alcohol and Drug Abuse;

licensed, certified, or approved as a Substance Abuse Treatment Program or center by any other state agency having legal authority to license, certify, or approve.

NOTE: Partial Hospitalization is covered as Inpatient care on a 2-for-1 exchange basis. That is, 2 sessions of Partial Hospitalization will count as 1 Inpatient day. A "session" is treatment for at least 4 hours but less than 24 hours in any 1 day and where no charge is made for room and board.

Surgery – Surgery-related expenses based on AMA (American Medical Association) guidelines.

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.

GENERAL PLAN INFORMATION

Name of Plan:
Midland County Employee Medical and Dental Benefit Plan

Plan Sponsor / Plan Administrator:
Midland County
Midland County Annex
2110 N. "A" Street, Suite 167
Midland, TX 79705
(432) 688-4880

Plan Sponsor ID Number (EIN):
75-6001069

Plan Number:
501

Plan Year:
January 1 through December 31

Plan Benefits:
Medical, Dental and Prescription Drug Program

Named Fiduciary:
Midland County
Midland County Annex
2110 N. "A" Street, Suite 167
Midland, TX 79705
(432) 688-4880

(See also definition of "Fiduciary")

Agent for Service of Legal Process:
Midland County
Midland County Annex
2110 N. "A" Street, Suite 167
Midland, TX 79705
(432) 688-4880

(Legal process may be served upon the Plan Administrator or a Fiduciary)

Contract Administrator:
Boon-Chapman Benefit Administrators, Inc.
9401 Amberglen Boulevard, Building I, Suite 100
Austin, TX 78729

FUNDING - SOURCES AND USES

Employee & Employer Obligations
Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer. If Plan benefits are part of an Employer-sponsored cafeteria plan under Section 125 of the Internal Revenue Code, such coverage costs may be deducted on a pre-tax basis.

Self-Funded Benefits
Contributions will be used to provide the non-insured benefits of the Plan.

Administration Expenses
Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

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

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. 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 which is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)
Certain benefits of the Plan 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 under this Plan in the absence of alternative benefits.

If the Plan 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 administer the Plan thereafter in strict accordance with the provisions of the Plan 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 exclusive right to, without the consent of any participant or beneficiary:

determine eligibility for benefits or to construe the terms of the Plan;

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; 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 which 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.

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 under the Plan), 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 Plan Document, the Plan Document will prevail.

Entire Contract
The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

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 Plan Document will not affect the other provisions and the Plan 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 under this Plan will be resolved by the Plan Sponsor under and pursuant to the 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.

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. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

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.

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 shall make determinations regarding Plan Benefits.

Privacy Rules & Intent to Comply
On and after April 14, 2003, (or effective April 14, 2004 if the Plan's premium equivalent is less than $5 million annually), the Plan Sponsor certifies that the Plan is amended (by separate addendum) to 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). See the section entitled **Privacy Rules** for more 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.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments which 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
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.

Termination for Cause
Coverage will terminate for an entire family unit (or a COBRA Qualified Beneficiary) in certain situations. Except as specified below, any termination will be effective immediately upon receipt by the Employee (or the COBRA Qualified Beneficiary) of a written notice from the Plan Sponsor. Any written notice will specify the reason for termination/rescission, the facts supporting such action, the effective date of the termination/rescission, and a notice that no expenses incurred after such date will be covered by the Plan. Coverage will end:

if a Covered Person makes a material misstatement in an application for initial coverage or a change in coverage with the intent to deceive. Coverage will be rescinded back to the original effective date and no coverage will ever have been in effect. A material misstatement will be deemed valid after two (2) years of continuous coverage after the making of the material misstatement;

if a Covered Person permits any other person to use of any evidence of coverage in their name (or the Employee's name in the case of a Dependent). This does not apply to an Employee with respect to his covered Dependents;

a Covered Person, singularly or in collusion with others, commits, attempt to commit, aids or abets claim fraud.

Titles or Headings
Where titles or headings precede explanatory text throughout the Plan 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 Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant.

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.

PRIVACY RULES

On and after April 14, 2003 (or effective April 14, 2004 if the Plan's premium equivalent is less than $5 million annually), the Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of "protected health information" (herein also "PHI") of Plan participants.

PHI is individually identifiable health information created or received by the Plan that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entities that may assist in the operation of the Plan.

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining his authorization, only if the use or disclosure is to carry out payment of benefits or for health care operations or if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities). For these purposes: "payment" means activities associated with eligibility and coverage determinations, coordination of benefits, claims management, utilization review and other related health plan administrative activities; "health care operations" means other health plan administrative tasks such as quality improvement activities, activities related to obtaining health insurance policies or stop loss insurance, and legal and auditing functions.

In order to comply with the Privacy Rules, the Plan Sponsor agrees to:

receive PHI from the Plan only when the entity providing PHI has received written certification that the Plan Document has been amended;

adopt privacy policies. Such policies will include the uses and disclosures the Plan will make with regard to protected health information of Plan participants and when and to whom such information (PHI) will or will not be disclosed. Those policies are incorporated into the Plan Document by reference;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentially of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions such as quality assurance, claims processing, auditing, monitoring and management of carve-out plans (such as vision or dental);

even when health information is used for payment and Plan operations, only the minimum necessary information will be requested and obtained;

not use or disclose PHI for employment-related purposes or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

not use or further disclose protected health information (PHI) other than as permitted or required by the Plan Document and by law;

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

make Plan participants' PHI available to them upon request in accordance with the Privacy Rules;

make Plan Participants' PHI available to them for amendment and correction in accordance with the Privacy Rules;

make PHI available as required to provide an accounting of non-routine disclosures;

make the Plan Sponsor's internal practices, books, and records related to uses and disclosure of PHI available to the Health and Human Services department for purposes of compliance enforcement;

when feasible, return or destroy all PHI received from the Plan once it is no longer needed;

provide for adequate separation of the Plan and the Plan Sponsor (i.e., create "firewalls"), by:

- identifying which specific employees, classes of employees or others under the control of the Plan Sponsor will have access to PHI and restrict that access to Plan administration purposes, and

- establishing a mechanism for resolving issues of noncompliance by the individuals who have access.

ensure that any agents or subcontractors of the Plan who receive PHI will abide by the same restrictions and conditions that apply to the Plan Sponsor;

train employees in privacy protection requirements and appoint a privacy official responsible for such protections;

provide sanctions for those employees who violate the policies;

establish grievance procedures for individuals who believe their privacy rights have been violated;

adopt (or assure that the component operating the Plan adopts) the data transmission standards and code sets as prescribed by the Health and Human Services (HHS) to promote administrative simplification and reduce administrative costs.

Required Separation between the Plan and the Plan Sponsor
In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:

Human Resources Administrator and Privacy Officer
Treasurer
Chief Deputy Treasurer
Payroll Administrator
Cash Management Administrator
Courier/Receptionist

This list reflects the employees, classes of employees or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

NOTE: The Privacy Rules requirements do not apply if the Employer is provided only with "summary health information" and the information is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is claims-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient identifying numbers or characteristics.

SECURITY RULES

On and after April 20, 2005 (or effective April 20, 2006 if the Plan's premium equivalent is less than $5 million annually), the Plan will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 165 (the "Security Regulations").

Definitions

Electronic Protected Health Information has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time, and generally means the protected health information that is transmitted or maintained in any electronic media.

Plan means the Midland County Employee Medical and Dental Benefit Plan

Plan Documents mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the Midland County Employee Medical and Dental Benefit Plan Document.

Plan Sponsor means Midland County.

Security Incidents has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

ADDENDUM FOR PRESCRIPTION DRUGS

PRESCRIPTION DRUG COVERAGE IS PROVIDED THROUGH SEPARATE AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND PRESCRIPTION DRUG VENDOR(S). IF THERE ARE ANY CONFLICTS BETWEEN THE PRESCRIPTION INFORMATION IN THIS DOCUMENT AND THE TERMS OF SUCH AGREEMENT(S), THE AGREEMENT(S) WILL PREVAIL.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

The Plan will pay 100% of the cost of eligible prescription drug expenses remaining after the co-payment stated in this section. The co-payments do not apply to the Medical Plan deductible or out-of-pocket maximum.

PRESCRIPTION DRUG PROGRAM: The Plan pays 100% after the member pays the applicable copayments shown.	**Per 30-Day Supply**	**Per 90-Day Supply**
• Generic	$15	$26
• Formulary Brand	$32	$65
• Non-Formulary Brand	$52	$104

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.

EXPENSES NOT COVERED

Prescription drug coverage will not include any of the following:

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

Devices - Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Durable Medical Equipment - Blood pressure kits, etc.

Excess Refills – Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.

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

Hair Loss Drugs - Any drug used for the treatment of hair loss (i.e., Minoxidil or "Rogaine").

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.

Non-Prescription Drugs - A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. 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.

ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2019.

Midland County

By: _____

Title: _____