COUNTY OF ROCKWALL

COMPREHENSIVE HEALTH CARE PROGRAM

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

EFFECTIVE: OCTOBER 1, 2006
REVISED: JANUARY 1, 2015

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

IMPORTANT MESSAGE

NOTIFY:

County of Rockwall

IF:

You get married

A child is born, adopted or placed for adoption

Your dependent child reaches the dependent age limit

You are divorced

You change your address

Notification is required within thirty-one (31) calendar days.

IT IS YOUR RESPONSIBILITY TO ENSURE THAT THE COUNTY OF ROCKWALL HAS UP-TO-DATE INFORMATION ON FILE FOR YOU, INCLUDING PROPER DOCUMENTATION FOR DEPENDENTS.

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ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document and Summary Plan Description (the "Plan Document") as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document is a restatement of any prior plan document, with benefit changes, and is effective on January 1, 2015.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for Eligible Employees of the Employer and their Eligible Dependents. The benefits provided by the Plan include:

HEALTH CARE COVERAGES
- Medical Coverage (Hospital, Physician Services, etc.)
- Dental Coverage
- Prescription Drug Card
- Vision Coverage

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed, effective as of January 1, 2015.

THE COUNTY OF ROCKWALL

By: _____

Title: _____

Date: _____

ADMINISTRATIVE INFORMATION

Name of Plan:	County of Rockwall Comprehensive Health Care Program
Plan Sponsor:	County of Rockwall 1111 East Yellowjacket Lane, Suite 310
Address:	Rockwall, TX 75087
Business Phone Number:	(972) 204-6100
Plan Sponsor ID Number (EIN):	75-6001129
Plan Number:	501
Plan Year:	January 1
Plan Benefits:	Medical, Dental, Vision, and Prescription Drug Card
Plan Administrator (Named Fiduciary):	County of Rockwall 1111 East Yellowjacket Lane, Suite 310
Address:	Rockwall, TX 75087
Business Phone Number:	(972) 204-6100
Designated Legal Agent:	County of Rockwall 1111 East Yellowjacket Lane, Suite 310
Address:	Rockwall, TX 75087

(Legal process may also be served upon the Plan Administrator.)

Participating Employers:	County of Rockwall
Contract Administrator:	Boon-Chapman Benefit Administrators, Inc.
Street Address:	3012 Ridge Road, Suite 204 Rockwall, Texas 75032
Mailing Address:	P.O. Box 1749 Rockwall, Texas 75087
Phone:	(972) 722-3400 / (800) 805-0622
FAX:	(972) 772-6097

SCHEDULE OF MEDICAL BENEFITS – COMPREHENSIVE PLAN

Annual Deductibles: (Applies after first dollar benefit is exhausted)

$750 Employee Only Coverage
$1,500 Employee Plus one or More Dependents

Annual Plan Year Maximum

(Includes All Other Maximums) None

First Dollar Benefit – In-Network Only

$500 Employee Only Coverage
$1,000 Employee Plus one or More Dependents

Non-PPO Hospital Admission Deductible:

$500 additional deductible per admission

Annual Out of Pocket Maximums:

(Including Deductible, and Prescription Drug Co-Pays)

PPO $4,000 Employee Only Coverage
$8,000 Employee Plus one or More Dependents
Non-PPO No Maximum - Individual
No Maximum - Family

The Plan will pay benefits to Covered Persons for Covered Expenses as described herein in accordance with the Schedule of Benefits. The Plan provides maximum benefits to the Covered Persons when they:

receive services or treatment from a provider who is a member of the Aetna Signature Administrators Network, a preferred provider organization; and

follow the procedures of the utilization management program described herein, which is administered by American Health Holding.

If you have questions about participating providers or need help finding a participating provider, call Aetna at 800-936-6340. A current list of PPO providers is available, without charge, through the Aetna website (located at www.aetna.com/asa). [If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Resources Department.]

If you have questions about the utilization management program, call American Health Holding at 800-641-5566.

The Contract Administrator of the Plan is Boon-Chapman Benefit Administrators, Inc. If you have other questions about the Plan (including questions about claims, premiums, and eligibility), call (972) 722-3400 or (800) 805-0622.

The following schedule summarizes the medical benefits of the Plan. Please refer to the remainder of the document for additional Plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays *	Additional Limitations and Explanations
Allergy Testing and Treatment			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Ambulance Services			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Anesthesia			
PPO	Yes	90%	See page 9 & 10 for additional
Non-PPO	Yes	60%	explanation
Chiropractic Care			
PPO	Yes	90%	$1,000 Calendar Year Maximum.
Non-PPO	Yes	60%	

*** Pays 100% (Network) after Out-of Pocket Maximum is met**

Benefit Description	Annual Deductible	Plan Pays *	Additional Limitations and Explanations
Durable Medical Equipment			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Hearing Aids (PPO & Non-PPO)	Yes	90%	Limited to one purchase per calendar year and $10,000 Lifetime Maximum.
Emergency Room (Emergency Use)			
PPO / Non-PPO	Yes	90%	
Emergency Room (Non-Emergency Use)			
PPO and Non-PPO - Facility	No	None	Not Covered
PPO – Physician	Yes	90%	
Non-PPO – Physician	Yes	60%	
Hearing Screening	No	100%	Up to $100 Per Calendar Year
Home Health Care			
PPO	Yes	90%	Up to 90 visits Per Calendar Year
Non-PPO	Yes	60%	
Hospital Services (Except Mental Health/Substance Abuse)			
PPO	Yes	90%	All Inpatient admissions must be pre-certified. Eligible Hospital expenses will have a $500 penalty if you do not follow the procedures required by the utilization management program. This penalty does not count toward the out-of-pocket maximum.
Non-PPO	Yes	60%	
Hospice Services			
PPO	Yes	90%	Up to 45 days Per Calendar Year
Non-PPO	Yes	60%	
Mental and Nervous Care / Substance Abuse Care			
PPO	Yes	90%	Inpatient – **Precertification Required Prior to Treatment.**
Non-PPO	Yes	60%	
Morbid Obesity			
PPO	Yes	90%	Maximum Benefit While Covered Under the Plan is $10,000.00 **Prior Authorization Required.**
Non-PPO	Yes	60%	
Outpatient Surgery			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Physician Office Visits			
PPO	Yes	90%	
Non-PPO	Yes	60%	

*** Pays 100% (Network) after Out-of Pocket Maximum is met**

Benefit Description	Annual Deductible	Plan Pays *	Additional Limitations and Explanations
Second Surgical Opinion			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Skilled Nursing or Convalescent Facility			
PPO	Yes	90%	Up to 60 visits Per Calendar Year
Non-PPO	Yes	60%	
Sleep Disorder			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Surgery (Physician Fees)			
PPO	Yes	90%	
Non-PPO	Yes	60%	
Therapy Services (Physical, Speech, etc.)			
PPO	Yes	90%	
Non-PPO	Yes	60%	
TMJ Treatment			
PPO	Yes	90%	Up to $1,000 Per Calendar Year
Non-PPO	Yes	60%	$5,000 Per Lifetime
Transplants			
PPO	Yes	90%	
Non-PPO	No	None	Out of Network Not Covered
Vision Care			Annual Eye Exam Pays up to $50.
PPO and Non-PPO	No	100%	Materials (Glasses or Contacts) Pays up to $250 Per Calendar Year
Wellness Benefit (PPO only)			**Out of Network Wellness Benefits Are Not Covered**
A. Routine Well Child Care	No	100%	
B. Early Detection Care For Employee and Covered Spouse	No	100%	Services are covered as recommended by the US Preventive Services Task Force (USPSTF) & immunizations will be covered as recommended by the Centers for Disease Control. All services listed are limited to no more than once annually or as recommended by the USPSTF.
C. Colonoscopy	No	100%	
D. Annual Gynecological Examination	No	100%	
E. Contraceptive Devices/ Injections	No	100%	
All Other Covered Expenses			
PPO	Yes	90%	
Non-PPO	Yes	60%	

*** Pays 100% (Network) after Out-of Pocket Maximum is met**

PRESCRIPTION DRUG CARD PROGRAM

The prescription drug card can be used to purchase prescription drugs at participating pharmacies.

Co-pays: **COMPREHENSIVE PLAN**

Retail (30 Day Supply)	
Generic	Lesser of 30% or $5
Preferred Brand	Lesser of 30% or $30
Non-Preferred Brand	Lesser of 30% or $60
Mail Order or Retail (When Written for a 90 Day Supply)	
Generic	Lesser of 30% or $10
Preferred Brand	Lesser of 30% or $60
Non-preferred Brand	Lesser of 30% or $120
Specialty Drugs	$60

Co-pays apply to prescriptions purchased through a participating pharmacy or a mail order program. Co-pays for the prescription drug card program do not apply to satisfying the major medical plan deductibles or out-of-pocket expenses. If prescription drugs are purchased without using the drug card, the reimbursement payable under the major medical plan will be subject to limitations stated in the Schedule of Benefits.

Maintenance prescriptions may be purchased retail or through a mail order program, and are limited to a 90-day supply. All other prescriptions purchased through a participating pharmacy will be subject to a 34-day supply.

See the section entitled "Medical Care Coverages - Eligible Medical Expenses - Prescription Drugs", for complete description of prescription drug provisions and limitations.

The prescription drug card program will be shown on the Employee identification card. For a list of participating pharmacies, please contact your Employer's benefits department or Boon-Chapman Benefit Administrators, Inc. at (800) 805-0622 or (972) 722-3400. A current list of participating pharmacies is available, without charge, through the prescription drug card vendor's website located at *www.envisionrx.com* . If you do not have access to a computer at your home, you may access this website at your place of employment.

The following OTCs (over-the-counter) are covered for $0 co-pay for up to a 34 day supply with a doctor's prescription:

- Claritin / Claritin-D (all forms to include generic cetirizine)
- Zyrtec/Zyrtec-D (all forms to include generic loratadine)
- Prilosec (all forms to include generic omeprazole)
- Allegra / Allegra-D (all forms to include generic fexofenadine)

Drugs that are excluded from $0 co-pay coverage:

- Clarinex / Clarinex-D
- Xyzal / Xyzal-D

Preventive Immunizations are covered for $0 co-pay at the pharmacy using your prescription card provided you have a prescription from your doctor. In the absence of a physicians prescription for a flu shot you may pay for the immunization at the pharmacy and obtain reimbursement by filing a paper claim form with Boon-Chapman.

ORGAN TRANSPLANT

ORGAN TRANSPLANT COVERAGE LIMITS

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue of the Covered Person. However, no coverage is provided for a transplant procedure that is not listed in the Schedule of Benefits.

The maximum benefit for all transplant procedures performed during a Covered Person's lifetime is shown in the Schedule of Benefits.

There is no coverage under the Plan for charges incurred in obtaining donor organs. However, expenses Incurred by a donor who is not ordinarily covered under this Plan according to participant eligibility requirements will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Plan Benefit still available to the recipient. This includes charges for:

a. evaluating the organ;

b. removing the organ from the donor; and

c. transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

Organ Transplant Exclusions

a. Non-human transplants. Mechanical organs, organs or bone marrow from sources other than humans are not covered.

b. Experimental or investigational transplants

DEFINITIONS AND EXPLANATION OF TERMS

(Refer to Schedule of Benefits)

First Dollar Benefits

This is the amount that the County of Rockwall provides you for any In-Network covered medical care expenses before your Annual Deductible applies.

- Employee Only - $500
- Employee Plus 1 or More Dependents - $1,000 (Combined Family Total)

Deductible

This is the amount of Covered Expenses you pay each Calendar Year after In-Network first dollar benefits are depleted.

There is a Calendar Year Deductible that applies to all Covered Persons as follows:

- Employee Only - $750
- Employee Plus 1 or More Dependents - $1,500 (Combined Family Total)

Benefit Maximums

The maximum payable for all eligible medical expenses for each covered person shall not exceed, in the aggregate, the maximum plan benefit listed in the schedule of benefits, which applies to all periods a person is covered under the plan. This Maximum Plan Benefit applies to all plans and plan options offered by the Employer.

When a Covered Person meets the Maximum Plan Benefit under one plan option, it will be considered met for all plan options offered by the Employer (if more than one is offered). Any lesser maximum benefit amounts are also applicable to all periods a person is covered under the plan. Other maximums may apply to specific periods, conditions, or types or levels of care and are as specified.

Plan Co-insurance

Plan Co-insurance is the portion of Covered Expenses that the Plan will pay, excluding those Covered Expenses that a Covered Person must pay;

a. as a Deductible;

b. as Co-insurance;

c. as Co-payment; or

d. because of a benefit maximum.

If a Covered Person does not comply with the utilization management program, eligible hospital expenses will be subject to a $500 penalty.

Exceptions to Plan Co-insurance
(Does not apply to transplants.)

a. If services are unavailable at a PPO facility, or in case of an emergency, the Plan's co-insurance level will be **90%**. The Co-insurance level of Covered Persons residing or traveling outside of a 60-mile radius from a network provider will be paid at the PPO Co-insurance level.

b. If a Covered Person goes into a PPO Hospital with a PPO doctor admitting, or if a Covered Person goes to a PPO hospital for outpatient services, the ancillary services (i.e. pathology, x-ray,

anesthesiology) performed by non-network providers who may be used by the hospital will be paid at the PPO co-insurance level.

c. All other Deductibles and benefit limitations apply and payment is based on the Maximum Eligible Charges.

Out-of-Pocket Maximums

Except as provided below, a Covered Person who is a participant in the Comprehensive Medical Plan shall not be required to pay, in one Calendar Year, more than $4,000 for Individual Coverage (deductible, prescription co-pays and 10% PPO medical coinsurance of eligible expenses) or $8,000 for Employee Plus 1 or More Dependent Coverage (deductible, prescription co-pays and 10% PPO medical coinsurance of eligible expenses) for the family to PPO providers for his Covered Expenses. Once he has done so, the Plan will pay 100% of his Covered Expenses for the remainder of the Calendar Year.

These out-of-pocket maximums do not apply to any Covered Expenses a Covered Person or covered family must pay:

a. as Co-insurance for out of network;

b. as Co-insurance because of failure to comply with the utilization management program;

c. as Co-insurance for transplants out of network;

d. because of a benefit maximum

UTILIZATION MANAGEMENT PROGRAM

Call (800) 641-5566

The Plan's utilization management ("UM") program is designed to encourage Covered Persons to obtain quality medical care in a cost-effective manner. The Plan's UM company is American Health Holding. The UM company does not diagnose or treat medical conditions. You can contact American Health Holding by telephone, mail, or fax. American Health Holding phone number is (800) 641-5566. American Health Holding mailing address is 7400 West Campus Road, New Albany, OH 43054. American Health Holding fax number is (614) 818-3236.

Each covered Employee should receive an identification card that contains instructions concerning the UM program. It should be carried by the Employee at all times and shown to all health care providers. The UM program requires that a Covered Person call American Health Holding in certain instances described below. It is always the Covered Person's responsibility to ensure that the call is made in a timely manner; however, the Covered Person's family or health care provider can make the call.

Pre-Admission Review

The Covered Person must call American Health Holding at least five days before a scheduled hospitalization. American Health Holding will review the Medical Necessity of the proposed admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits.

Concurrent Care Review

If a Covered Person needs to stay in the Hospital longer than originally authorized, the Covered Person must call American Health Holding within 3 business days. The UM company will review the Medical Necessity of the request and notify the individual or the provider whether the additional stay is authorized as Medically Necessary. If the authorization for the additional stay is not requested in accordance with this paragraph, any Covered Expenses will be reduced as described in the Schedule of Benefits. In an Urgent or Emergency Care Situation, the Covered Person must notify American Health Holding within 48 hours after the additional stay begins.

Urgent and Emergency Admission Review

In an Urgent Care Situation a covered person must call American Health Holding within 48 hours following the start of an emergency admission unless the person is incapacitated. If incapacitated, the covered person must call as soon as possible thereafter. The term "incapacitated" means the physical or mental inability of the covered person to precertify his or her admission. American Health Holding will review the medical necessity of the admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits.

Case Management

The Plan Administrator, working with American Health Holding, may elect to provide alternative benefits and may assign a case manager when it believes a patient's condition requires complex, specialty or long-term care. The case manager will attempt to coordinate health care services through direct interaction with the Covered Person, his or her family, or his or her Physician in an effort to achieve quality care in a cost-effective manner. The Plan Administrator will exercise discretion and give direction to American Health Holding as appropriate. Case management may occur in an Inpatient or an Outpatient setting.

A Covered Person must call American Health Holding within 30 days of learning that she is pregnant. In addition, a Covered Person must call American Health Holding within five days of becoming a possible candidate for an organ transplant.

Further, except in an Urgent Care Situation, a Covered Person must call before

a. receiving hospice care;

b. being admitted into a Skilled Nursing Facility.

In an Urgent Care Situation a Covered Person must contact American Health Holding within 48 hours after receiving services. If American Health Holding is not contacted in accordance with these provisions, then Covered Expenses will be reduced as described in the Schedule of Benefits. If a Covered Person contacts American Health Holding in accordance with these provisions, but does not follow American Health Holding recommended course of treatment, then benefits will not be reduced provided the services received are Medically Necessary.

Plan Administrator Utilization Management Discretion

The Plan Administrator shall have the discretion to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of care.

Effect of Obtaining an Authorization

The authorization of admission, care or services does not guarantee the payment of benefits. Eligibility and payment of benefits are subject to all of the terms and provisions of the Plan.

MEDICAL CARE COVERAGES ELIGIBLE MEDICAL EXPENSES

Except as otherwise noted below or in the medical Schedule of Benefits, Covered Expenses are the Maximum Eligible Charges for services listed below that are Incurred by a Covered Person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. In general, services and supplies must be approved by a Physician and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy, or other covered health care conditions.

Abortion
Covered Expenses are limited to abortions that eliminate a substantial danger to the mother's life, but expenses Incurred as a result of medical complications arising from an abortion are also covered.

Alcoholism
See the definition of Mental and Nervous Care/Substance Abuse. Also see the Schedule of Benefits for possible limitations.

Each full day of outpatient treatment or residential treatment of partial care hospitalization or intensive out-patient programming will be considered as one half day of in-patient care.

Allergy Testing
See Schedule of Benefits for possible limitations.

Ambulance
Professional local ambulance service by a state-licensed ambulance company to the nearest Hospital in connection with care for a medical emergency or Accidental Injury. An air ambulance will be covered when needed to transport a Covered Person to the nearest Hospital equipped to render appropriate care.

Ambulatory Surgical Center/Licensed Surgical Facility

Anesthesia
The charges made for anesthetics and by a Physician or Nurse Anesthetist for the administration of anesthesia. If both an anesthetist and a Nurse Anesthetist are utilized, covered charges are limited to Maximum Eligible Charges of an anesthetist for the covered operative procedure.

Assistant Surgeon
The Plan will cover charges by an assistant surgeon when Medically Necessary due to the nature of the procedure being performed. The Plan will allow up to twenty-five percent (25%) of the primary surgeon's Covered Expenses.

Birthing Centers

Blood
The charges for blood and blood plasma (if not replaced by or for the patient), including blood processing charges. Expenses for storage of autologous blood or blood plasma are covered.

Cardiac Rehabilitation
Charges for cardiac rehabilitation therapy treatment when rendered by a registered therapist under the supervision of a Physician. Cardiac rehabilitation therapy expenses are Covered Expenses subject to the following:

a. The Covered Person must be recovering from a myocardial infarction (heart attack), cardiovascular surgery or a diagnosis of angina pectoris but only when the diagnosis is established prior to the start date of the cardiac rehabilitation program as evidenced by a record of prior treatment,

b. A Physician who is receiving regular progress reports concerning the Covered person's progress must prescribe cardiac rehabilitation therapy,

c. Cardiac rehabilitation therapy must be conducted at a medical facility,

d. Proper monitoring equipment and qualified medical personnel must be present during cardiac rehabilitation therapy in order to effectively respond to any emergency situation,

e. In order for charges for therapy which extend beyond twelve (12) weeks following a myocardial infarction, coronary surgery or angina pectoris to be considered as Covered Expenses, medical documentation is required to establish the necessity for the extension,

f. The Covered Person is not on a maintenance exercise program, and

g. Continuation of the monitored exercise program is necessary to enable the Covered Person to reach an acceptable level of individual exercise tolerance consistent with the particular state of this person's disease.

Casts, Splints, Trusses, and Surgical Dressings

Chemical Dependency
See the definition of Mental and Nervous Care/Substance Abuse. Also see the Schedule of Benefits for possible limitations.

Chemotherapy

Chiropractic Care
Manipulation to correct such vertebral disorders as incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing. See Schedule of Benefits for possible limitations. Care must be provided by a properly licensed doctor of chiropractic.

Circumcision

Clinical Trials (Routine Patient Costs)
The Plan will not terminate coverage, reduce benefits under the Plan, or otherwise discriminate against a Covered Person due to the Covered Person's participation in a Clinical Trial, provided that the Covered Person meets the following requirements:

1. The Covered Person is eligible to participate in a Clinical Trial according to the Clinical Trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
2. The Covered Person's participation in such Clinical Trial would be appropriate based upon the Covered Person's eligibility to participate according to the Clinical Trial protocol:
   a. As concluded by the referring health care professional who is a participating health care provider in the Clinical Trial; or
   b. As established by medical and scientific information provided by the Covered Person.

The Plan will not deny, or limit or impose additional conditions on, routine Covered Expenses for services and supplies that are furnished in connection with participation in the Clinical Trial, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. In no event will the Plan cover services or supplies Out-of-Network unless Out-of-Network benefits are otherwise provided under the Plan.

The Plan may require a Covered Person who desires to participate in a Clinical Trial that is conducted in the State in which the Covered Person resides to participate through a Network Provider, if one or more Network Providers are participating in a Clinical Trial and the Network Provider will accept the Covered Person as a participant in the Clinical Trial.

For purposes of this section, "Clinical Trial" means an "approved clinical trial" as defined in Section 2709 of the Public Health Service Act. Contact the Contract Administrator for additional information.

Dental Care

a. treatment of fracture of facial bones;

b. excision of lesions of the mandibular joints, mouth, lips, or tongue;

c. incision of accessory sinuses or mouth salivary glands or ducts;

d. treatment of dislocation of the jaw;

e. plastic reconstruction or repair of the mouth or lips necessary to correct or repair traumatic injury or congenital defect, which includes any appliances, orthodontia treatment, or other scheduled treatment plans to correct or repair such traumatic injury or congenital defect; or

f. treatment required because of Accidental Injury to natural teeth. Such expenses must be incurred within six months of the date of the accident (unless otherwise required by applicable law);

g. hospitalization for dental work for a child under the age of two (2) or other person incapable of having such work performed in the dentist office.

Diabetic Training

Diagnostic Services
Diagnostic laboratory and x-ray expenses, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by Physicians throughout the United States. See also "Pre-Admission Testing".

Drug or Substance Abuse
See "Chemical Dependency."

Durable Medical Equipment
Rental of Durable Medical Equipment (but not to exceed the purchase price) or purchase of such equipment, where only purchase is permitted, prescribed by a Physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of a Sickness or Accidental Injury. Purchase or rental of luxury medical equipment (e.g., motorized wheelchairs or other vehicles or bionic or computerized artificial limbs) is not covered when standard equipment is appropriate for the patient's condition. Hearing Aids and special attachments for phones to aid in hearing are Covered under Durable Medical Equipment, See Schedule of Benefits for Limitations

Emergency Room Treatment

Hearing Aid
See Durable Medical Equipment.

Hearing Screening
See Schedule of Benefits for possible limitations.

Home Health Care
Covered Expenses are limited to those for services listed herein that are furnished by a Home Health Care Agency to a Covered Person who is under the care of a Physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending Physician, and the orders must be renewed at least every 30 days. The attending Physician must also certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan.

Covered Expenses for home health care visits are limited to those made by:

a. a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);

b. home health aides under supervision of a R.N.;

c. physical, occupational, and speech therapists; or

d. a licensed midwife.

Covered home health care expenses will also include medical supplies, drugs, and medicines prescribed by a Physician, laboratory services, and special meals prescribed by a Physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the Covered Person had remained in the Hospital.

Home Infusion Therapy

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 Services
Covered Expenses include:

a. The actual room and board expenses incurred for a room up to the limits as shown in the Schedule of Benefits

b. the actual expense incurred for confinement in an intensive care unit, cardiac care unit or burn unit, up to the limit shown in the Schedule of Benefits;

c. all other Medically Necessary services and supplies furnished by the Hospital, but not for private-duty nursing care.

See Schedule of Benefits for pre-certification requirements and preferred provider arrangements that may determine the level of benefits.

Hospital audits by an independent auditing firm will be considered Covered Expenses under the Plan.

Laboratory Tests

Mastectomy Reconstruction

a. Covered Expenses include the following in connection with a covered mastectomy:

b. reconstruction of the breast on which the mastectomy has been performed;

c. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

d. prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Mental Health Care
See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.

Each full day of day of outpatient treatment or residential treatment of Partial Care hospitalization or intensive out-patient programming will be considered as one half day of in-patient care.

Midwife
Services of a registered nurse midwife.

Multiple Surgical Procedures
Multiple surgical procedure allowances are specified below:

Primary procedure, bilateral primary procedure, or add-on to primary procedure: maximum eligible charge or negotiated fee;

Secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Bilateral secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Add-on to secondary procedure in same operative area: limited to 50% of maximum eligible charge or negotiated fee;

Separate (incidental) procedure in same operative area as any of the above: not covered;

Separate operative area: maximum eligible charge or negotiated fee.

Newborn Care
Hospital and Physician services rendered during the birth confinement to a covered newborn child (including such charges of a well newborn).

Nicotine Addiction
Treatment for nicotine addiction is covered for generic and OTC treatments with no co-pay. Chantix is limited to Two (2) courses of treatment per lifetime.

Nursing Services
The charges made by a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) for private-duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type and when performed in the Covered Person's home. See Schedule of Benefits for possible limitations.

Obesity/ Morbid Obesity
Charges for services, devices, procedures or treatments directly related to treatment of Obesity if there are significant associated medical complications. Charges for services, surgery or supplies directly related to treatment of Morbid Obesity, whether or not associated with or as a result of metabolic, vascular, endocrine or any other medical condition. See schedule of benefits for limitations.

Organ Transplants
The following are organ transplant provisions of the Plan:

Services and supplies in connection with transplant procedures, subject to the following conditions;

a. Case management is required by the utilization management organization for all services.

b. A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialty training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

c. If the donor is covered under this Plan, Covered Expenses Incurred by the donor will be considered for benefits.

d. If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be considered for benefits. Expenses Incurred by a donor who is not ordinarily covered under this Plan according to participant eligibility requirements will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Plan Benefit still available to the recipient.

e. If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person will be treated separately for each person.

f. The Maximum Eligible Charge of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered a Covered Expense.

Over-the-Counter Drugs
Over-the-Counter drugs that are eligible for benefit consideration when prescribed by a physician. Claims for certain Over-the-Counter drugs listed in the schedule of benefits must be processed by the pharmacy in order to be covered under this program. Purchase of this medication without a prescription will not be covered under this program.

Outpatient Surgery
Covered Expenses incurred in connection with any surgical procedure that is performed on an Outpatient basis in a Hospital, Ambulatory Surgical Center, or Physician's office. Charges must be incurred on the same day as the Surgery, except that tests required by the Hospital because of the Surgery will be covered if they are incurred within fifteen days prior to the Surgery.

Oxygen
Oxygen, and services and supplies for the administration of oxygen.

Pathology

Physical Therapy
The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services
The charges made by a Physician for medical and surgical treatment.

Pre-admission Testing
The charges for diagnostic tests performed on an Outpatient basis prior to a scheduled Hospital admission when the tests are performed within seven days before admission to the Hospital and the patient is subsequently admitted to the Hospital.

Preferred Provider Organization
If a preferred provider organization (PPO) is shown in the Schedule of Benefits, then the PPO negotiated fees with healthcare providers will be considered the Maximum Eligible Charge.

Pregnancy
Pregnancy expenses of a covered Employee or covered Spouse are covered to the same extent as any Sickness.

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

Prescription Drugs
Covered prescription drug expenses are limited to those for:

a. drugs which have been approved by the FDA

b. prescription legend drugs (i.e. any medicinal substance whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription")

c. any other drugs that under the applicable state or federal law may be dispensed only upon the written prescription of the Physician;

d. Injectable insulin, insulin syringes, blood glucose monitors, chemstrips, and blood lancets;

e. contraceptives (0ral, Nuva Ring and Other Devices);

f. tretinoin used for acne, all dosage forms (e.g. Retin-A), for individuals under age 25 years (Prior Authorization required.)

g. immunosuppressant's;

h. injectable drugs which have been approved by the FDA

i. vitamins (singly or in combination) Prenatal vitamins are covered;

j. Claritin / Claritin-D (all forms to include generic cetirizine) Zyrtec/Zyrtec-D (all forms to include generic loratadine) Allegra / Allegra-D (all forms to include generic fexofenadine), Prilosec (all forms to include generic omeprazole)

and do not include those expenses for:

a. Tretinoin, all dosage forms (e.g. Retin-A), for individuals 25 years of age or older;

b. anorectics (drugs used for the purpose of weight control);

c. Rogaine (minoxidil);

d. dietary supplements;

e. non-legend drugs other than insulin;

f. charges for the administration or injection of any drug;

g. therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances regardless of their intended use, except those listed above;

h. prescriptions that a Covered Person is entitled to receive without charge under any workers' compensation law;

i. medication that is to be taken by or administered to an individual, in whole or part, while he is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

j. any quantity of drugs or medicines dispensed that exceeds a 34-day supply, when taken in accordance with the direction of the prescriber; unless provided through a mail order program or 90-day retail specified in the Schedule of Benefits.

k. infertility medications; erectile dysfunction medications; and

l. any prescription refilled before 15% of the supply is used or in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.

Preventive Health Services

Subject to the limitations below, Covered Expenses Incurred for periodic preventive health services recommended for a Covered Person's age and gender as indicated and required under 29 CFR § 2590.715-2713(a)(1) will be reimbursed at 100% (no cost-sharing, such as a Deductible, Co-insurance or Co-payment will apply). If an item or service required to be covered as a preventive health service under 29 CFR § 2590.715-2713(a)(1) is billed separately from an office visit, then a Co-payment, Co-insurance or Deductible may be applied to that office visit. If the item or service required to be covered under 29 CFR § 2590.715-2713(a)(1) is not billed separately from the office visit and the primary purpose of the office visit is to obtain the preventive care, then no Co-payment, Co-insurance or Deductible may apply to such office visit and preventive care service. If the item or service required to be covered under 29 CFR § 2590.715-2713(a)(1) is not billed separately and the primary purpose of the office visit is not to obtain the preventive service, then a Co-payment, Co-insurance or Deductible may be applied to the office visit. Preventive health services provided by non-PPO providers are not Covered Expenses**. Out of Network Not Covered**.

Prosthetic Appliances
Covered Expenses are limited to those for:

a. an initial temporary and permanent Prosthesis required to replace natural body parts lost or removed;

b. an initial Prosthesis required to aid the function of body organs; and

c. a replacement Prosthesis necessitated by the growth of a child.

Radiation Therapy
Radium and radioactive isotope therapy.

Radiology and X-rays

Respiratory Therapy
The charges for the professional services of a licensed respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Second or Third Surgical Opinion
Charges from Physicians are covered as follows:

a. A Physician who is qualified through work experience, specialized training, or similar criteria must render services.

b. The Physician must not be affiliated in any way with the Physician who rendered the first opinion or with the Physician who will be performing the actual surgery.

Skilled Nursing Facility
Covered Expenses are limited to Skilled Nursing Facility room and board and services when the confinement is approved and reviewed every 30 days by the utilization management organization.

Sleep Disorders Treatment
Covered Expenses are limited to treatment of apnea and narcolepsy.

Speech Therapy
Services by a qualified speech therapist when specifically prescribed by and under the direct supervision of a Physician, to restore or rehabilitate any speech loss or impairment caused by Accidental Injury or Sickness except a mental, emotional, or nervous disorder. In the case of a congenital defect that can be corrected or improved with Surgery, expenses will be considered only if incurred after Surgery for the defect.

Sterilization Procedures
Sterilization procedures for Employees and spouses ONLY.

Temporomandibular Joint Dysfunction (TMJ)
See the Schedule of Benefits for possible limitations.

Urgent Care Facilities
A freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board-certified Physician, a licensed registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, and x-ray and laboratory equipment and a life support system. An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made a part of, a regular Hospital.

Vision Care Under the Medical Plan Following Cataract Surgery
Covered Expenses are limited to the initial purchase of glasses or contact lenses following cataract Surgery covered by the Plan.

Wellness Benefit
See Schedule of Benefits for possible limitations.

MEDICAL LIMITATIONS AND EXCLUSIONS

In addition to the General Health Care Coverage Exclusions, the Plan will not provide benefits for any of the services and supplies listed in this section. Further, the Plan only covers those expenses specifically described as covered in the preceding section. Consequently, there may be expenses in addition to those listed below which are not covered by the Plan.

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

Acupuncture

Air Purification Units
Air conditioners, air-purification units, humidifiers, or electric heating units.

Biofeedback

Blood
Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.

Breast Implants
Except as provided under the Mastectomy Reconstruction provision in the Covered Medical Expenses section, breast implants placed for cosmetic reasons, removal, reconstruction or re-implantation due to complications are not covered. There will be coverage if there is documentation of leakage of a silicone implant and/or a positive silicone antibody study for removal of implants only.

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

Dental Care
Care or treatment of or to the teeth, alveolar processes, or gingival tissue or for malocclusion is not covered. Replacement of teeth that were broken due to a chewing injury is not covered.

Diagnostic Hospital Admissions
Hospital confinement for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Exercise Equipment
Exercising equipment, vibratory equipment, or swimming or therapy pools.

Foot Care (routine)
Expenses Incurred for the non-surgical treatment of the feet, treatment of corns, calluses, or toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Expenses Incurred for orthopedic shoes (except when permanently attached to braces) and other supportive appliances for the feet.

Hair Transplants

Hypnosis

Impregnation
Artificial insemination, in-vitro fertilization, or any other type of artificial impregnation procedure.

Infertility
Charges for services to restore or enhance fertility, including but not limited to, artificial insemination, in vitro fertilization.

Military Service
Charges related to or in connection with any Injury or Illness incurred while on active duty in a military service.

Occupational Therapy
Occupational therapy (except during Hospital confinement or as included in home health care services) or vocational, educational, recreational, art, dance, or music therapy.

Personal Comfort or Convenience Items
Services or supplies provided for personal comfort including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets, mattress covers, wigs, non-prescription drugs and medicines, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments for such equipment.

Pregnancy
Charges related to a surrogate mother are not covered. Pregnancy of a dependent child is not covered.

Prescription Drugs - Outpatient
Outpatient prescription drug coverage is provided only under the terms of the "Prescription Drugs" section in Medical Care Coverages – Eligible Medical Expenses.

Psychiatric Testing, Counseling, or Therapy
Except as may be specifically provided herein, the Plan does not cover psychiatric or psychological testing or evaluation (unless specifically related to the treatment of a psychiatric condition), hypnotherapy, or marriage or family counseling; treatment of learning disorders, behavioral problems, development delays, mental retardation, or autism of childhood; vocational testing, evaluation, or counseling; or therapy or counseling for sexual dysfunctions or inadequacies.

Retiree Hospital & Medical Benefits
Participation in this plan is limited to retirees and their eligible covered dependents from the date of qualification and election until attainment of age 65. At age 65 each individual retiree's or dependent's coverage will terminate.

Self-Procured Services
Charges for services rendered to a Covered Person who is not under the regular care of a Physician or charges for services, supplies, or treatment, including any period of Hospital confinement, not recommended, approved, and certified as Medically Necessary and reasonable by a Physician.

Sex-Change Procedures
Sex-change counseling or treatment, services incident to sex-change procedures, surgery, drug therapy, or any resulting complications.

Sterilization Reversal Surgery
Expenses Incurred for the reconstruction (reversal) of a previous sterilization procedure.

Weight Control
Weight loss programs, whether or not prescribed by a physician. See schedule of benefits for possible coverage.

Wigs and Wig Maintenance
Charges for wigs with exception of hair loss due to a prescribed medical regime, e.g. chemotherapy.

SCHEDULE OF DENTAL BENEFITS - COMPREHENSIVE PLAN

Calendar Year Deductibles	Lifetime Orthodontic Benefit Maximum	Calendar Year Benefit Maximums
$ 50 Individual No Family Maximum	$2,000 Individual	$2,000 Individual

The following schedule summarizes your dental benefits. Please refer to the remainder of the document for additional Plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
Preventative Services	No	100%	Subject to the annual calendar year maximum.
Basic Services	Yes	80%	Subject to the annual calendar year maximum.
Major Services	Yes	50%	Subject to the annual calendar year maximum.
Orthodontic Services	Yes	50%	Subject to the lifetime orthodontic maximum. Orthodontia expenses do not apply toward the annual calendar year maximum.

Note: The word "lifetime" refers to the period of time a Covered Person is a participant in this Plan or any other plan sponsored by the County of Rockwall

About Your Dental Benefits
All benefits under this dental benefit must satisfy some basic conditions. The following are commonly included in dental benefit plans but are often overlooked or misunderstood.

Deductibles
A deductible is the amount of Covered Expenses you must pay during a Calendar year before the Plan begins to consider expenses for reimbursement.

The annual individual Deductible amount is shown on the Schedule of Dental Benefits.

Co-insurance
Co-insurance percentages represent the portions of Covered Expenses paid by you and by the Plan after satisfaction of any applicable Deductible. These percentages apply only to Covered Expenses which do not exceed Usual, Customary and Reasonable Charges. You are responsible for all non-Covered Expenses and any amount which exceeds the Usual, Customary and Reasonable Charges for Covered Expenses.

The Co-payment percentages Paid by the Plan are shown on the Schedule of Dental Benefits.

Benefit Maximums
Total dental payments for each Covered Person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. Whenever the word lifetime appears in this Plan in reference to benefit maximums, it refers to the period of time you participate in this Plan or any other plan sponsored by the County of Rockwall.

The benefit maximums applicable to this dental benefit are shown on the Schedule of Dental Benefits.

DENTAL CARE COVERAGES

Covered Expenses
Except as otherwise noted below or in the dental Schedule of Benefits, Covered Expenses are the Usual, Customary and Reasonable Charges for services listed below that are Incurred by a Covered Person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. The Plan provides benefits only for the most cost-effective treatment of a dental condition, which provides a professionally acceptable result as determined by national standards of dental practice. Services or supplies that do not meet accepted standards of dental practice, or are not furnished by a Dentist, except for x-rays or services rendered by a Dental Hygienist under the supervision of a Dentist, will not be covered.

Covered Preventative Services
The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the plan.

a. Oral examination, no more than two such examinations in any twelve (12) consecutive month period.

b. Prophylaxis, no more than two such prophylaxes in any twelve (12) consecutive month period.

c. Bite-wing x-rays limited to no more than two in a consecutive twelve (12) month period.

d. Full mouth x-rays limited to once in any period of thirty-six consecutive months.

e. Other x-rays necessary to diagnose a dental condition.

f. Topical application of sodium or stannous fluoride, but not more than one such treatment or series of treatments in any twelve (12) consecutive month period.

g. Sealants, limited to children under the age of 19.

Space maintainers that replace prematurely lost teeth for children under 16 years of age, including any adjustments more than six months after installation (limited to initial appliances only).

Covered Basic Services
The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the plan.

a. Emergency palliative treatment.

b. Professional consultation recommended by the attending dentist.

c. Tooth extractions.

d. Administration of general anesthesia and/or intravenous sedation in connection with oral surgery.

e. Oral surgery.

f. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration for decayed teeth.

g. Endodontic treatment, including root canal therapy.

h. Periodontal treatment, including diagnosis, scaling and surgery. Gingival curettage will be limited to four quadrants in any period of twelve consecutive months.

i. Injection of antibiotic drugs by the attending dentist.

Covered Major Services
The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services according to all provisions, requirements and limitations of the plan.

a. Crowns – Single Restorations only (Acrylic, Porcelain, Gold, Stainless Steel, or combination).

b. Inlays, on-lays, gold fillings, and crown restorations to restore diseased teeth, but only when the tooth, as a result of extensive caries, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling restoration.

c. Repair or re-cementing of crowns, inlays, on-lays, bridgework, or dentures.

d. Adjusting, relining or rebasing of dentures more than six months after the installation of an initial or replacement denture, but not more than one relining in any period of twelve consecutive months or one rebasing in any period of thirty-six months.

e. Initial installation of fixed bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth which were extracted while covered under this plan.

f. Replacement of an existing partial or full removable denture or fixed bridgework; the addition of teeth to an existing partial or removable denture; or, bridgework to replace teeth which were extracted if satisfactory evidence is presented to the plan that:

   - The addition of teeth is necessary to replace one or more teeth extracted after the existing denture or bridgework was installed and while a participant in the plan.

   - The existing denture or bridgework cannot be made serviceable and was installed at least 5 years prior to the replacement date.

   - The existing denture is an immediate temporary denture replacing one or more natural teeth extracted while participating in the plan, replacement by a permanent denture is required, and the replacement takes place within 12 months from the placement of the temporary denture.

g. Replacement of crowns, inlay, or on-lay restorations by new crowns, inlay, or on-lay restorations, but only if satisfactory evidence is presented that the existing crown, inlay, or on-lay restoration cannot be made serviceable and at least five years have elapsed prior to its replacement.

Covered Orthodontic Services

a. The plan will provide benefits, as outlined on the Schedule of Dental Benefits, for expenses related to orthodontic services according to all provisions, requirements and limitation of the plan.

b. Necessary services related to an active course of orthodontic treatment, including but not limited to tooth extractions and x-rays.

c. The initial and subsequent, if any, installation of orthodontic appliances, endodontic appliances, and periodontal appliances for an active course of orthodontic treatment.

d. Adjustment of active orthodontic appliances.

e. Treatment of temporomandibular joint dysfunction (TMJ), including diagnosis and appliances.

DENTAL LIMITATIONS AND EXCLUSIONS

In addition to the General Health Care Coverage Exclusions, the Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by this Plan. The Plan only covers those expenses specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

Drugs
The administration or cost of drugs, unless otherwise specified.

Duplicate Services
Duplicate prosthetic devices, other duplicate appliances, or duplicate dental restoration.

Medical Services
Benefits otherwise provided under a medical plan.

Non-Covered Services
Services not specifically listed as Covered Expenses, which include but are not limited to the following:

a. expenses used to satisfy Plan Deductibles;

b. training, educational instruction or materials relating to dietary counseling, personal oral hygiene or dental plaque control;

c. services and supplies for personalization or characterization of prosthetic devices;

d. procedures and appliances to increase vertical dimension or restore occlusion;

e. tooth implants;

f. myofunctional therapy;

g. athletic mouth guards;

h. duplicate prosthetic devices or appliances;

i. appliances for the correction of harmful habits, such as grinding the teeth, thumb sucking, etc.;

j. precision or semi-precision attachments;

k. periodontal splinting;

l. veneers;

m. hospital charges; and

n. expenses for services performed after the date coverage ends under this Plan. If services are provided within 31 days of the date coverage ends, coverage will be provided for:

   - installation or adjustment of dentures or fixed bridgework if the impressions were taken prior to the date coverage ended;
   - crowns, inlay or on-lay restorations if the tooth or teeth were prepared prior to the date coverage ended; and
   - root canal therapy if the pulp chamber was opened prior to the date coverage ended.

Non-Standard Services
Services or supplies that do not meet accepted standards of dental practice, including charges for implantology and for services and supplies that are experimental in nature or not fully approved by a council of the American Dental Association.

Services not reasonably necessary or not customarily performed, or for charges exceeding the Usual, Customary and Reasonable Charges for the service performed or materials furnished.

Orthodontics
Orthodontic services and/ or treatment, except as specified in the Covered Dental Expenses section.

Pre-existing Conditions
Unless otherwise required by applicable law, services for:

a. an appliance or modification of an appliance if the impression was made prior to becoming a Covered Person;

b. a crown, inlay, on-lay bridge, or cast restoration if tooth preparation was made prior to becoming a Covered Person;

c. root canal therapy if the chamber was opened prior to becoming a Covered Person; or

d. any dental expense Incurred prior to the effective date of this Plan.

Replacement Prosthetics
Replacement of a lost, missing, or stolen prosthetic device or any other appliance.

Services Not Furnished by a Dentist
Services not furnished by a Dentist, except for x-rays ordered by a Dentist and services performed by a licensed Dental Hygienist under the supervision of a Dentist.

GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all benefits for expenses incurred for treatment, services and supplies provided under this Plan, and no benefits shall be payable for the following:

Cosmetic Services
Any Surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except when:

a. necessary due to a non occupational Accidental Injury;

b. necessary for correction of post surgical deformity.

Court-Ordered Confinement
Any confinement of a Covered Person in a public or private institution as the result of a court order.

Criminal Activities
Any Injury or any complication thereof occurring during the Covered Person's commission of a felony offense or in the immediate flight there from. Any condition, disability or expense sustained as a result of being engaged in an illegal occupation, commission, or attempted commission of an assault or other illegal act, including injuries sustained while under the influence of drugs and/or alcohol.

Education or Training Program
Services performed by a Physician or other provider enrolled in an education or resident training program when such services are related to the program.

Excess Charges
which exceed the Maximum Eligible Charges for non-participating providers, or the negotiated fees for participating network providers.

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

Government-Operated Facilities
The Plan does not cover loss caused by or resulting from confinement or treatment for which the Covered Person is not legally obligated to pay, such as in any government hospital. However, the U.S. government has a right to recover or collect benefits for any care or services Incurred by a Covered Person as a result of a non-service-connected Injury or Illness. The U.S. government may recover or collect to the extent that the Covered Person would be eligible to receive benefits under this Plan if such care or services had not been furnished by a department or agency of the United States.

Immediate Family or Resident Care
Any service rendered to a Covered Person by a member of the Covered Person's Immediate Family or anyone who customarily lives in the Covered Person's household.

Incorrect and/or inappropriate coding and/or billing practices
Any portion of a claim that the administrator determines to be incorrectly or inappropriately billed by a physician, health professional, facility or hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period or take place on the same day, duplicate services, and inappropriate modifier use. The determination that a service was incorrectly or inappropriately billed is based on documentation from the Centers for Medicare and Medicaid Services, The National Correct coding Initiative and/or other coding vendors or industry regulatory agencies.

Investigative, Experimental, or Research Procedures
which are still considered experimental or investigational (as defined by the Plan), whether or not such treatment, services or supplies are “generally accepted” by the medical profession.

Late-Filed Claims
Claims that are not filed with the Contract Administrator for handling within 12 months after the date the expenses are Incurred.

Medical Appropriateness
For any services which do not meet the criteria for clinical eligibility for coverage for the diagnosis and treatment of an illness or injury, unless stated otherwise as covered in the plan; which are not recommended or approved by the attending physician; or which are not generally accepted in the United States as being necessary and appropriate for the treatment of the patient's illness or injury.

Military Service
Charges for treatment of any Injury sustained or Illness contracted while in the military service of any country.

Miscellaneous Expenses
for postage, shipping and handling charges, sales tax, and interest or finance charges.

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

No Charge/No Legal Requirement to Pay
Services for which no charge is made or for which a Covered Person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this Plan.

Other Coverage
Health care services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

Outside United States
Charges Incurred outside of the United States if the Covered Person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

Prior to or After Coverage
Services or supplies that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Self-Inflicted Injury
for intentionally self-inflicted injury, unless such injury results from a medical condition (physical or mental health condition) or domestic violence.

Travel
for travel or accommodations, whether or not recommended by a physician, unless approved by the utilization management organization.

War
Medical or dental conditions resulting from invasion, insurrection, war (declared or undeclared), any act of war or terrorism, or riot and any complications there from, or service in the armed forces of any country.

Work-Related Injury or Sickness
Any injury or sickness that is caused by, or connected in any way to employment of the covered person. (This includes self employment or employment by others.) It applies whether or not workers' compensation or similar law covers the expenses incurred. This exclusion applies to accidental injury or illness arising out of or in the course of any employment for wage or profit and which is covered by Workers Compensation or Occupational Disease Policy, or any expenses payable under compromise settlement agreements arising from a Workers Compensation claim. If the Covered Participant is seeking coverage for expenses incurred for treatment, services and supplies for accidental injury or illness arising out of or in the course of any employment for wage or profit, the Covered Participant will be required to provide evidence of denial of his or her claim under Workers Compensation or Occupational Disease Policy in order to substantiate that this exclusion does not apply.

NOTE: All of the exclusions in this section include complications resulting from any excluded coverage, including, but not limited to, any reversal procedure unless stated otherwise.

COORDINATION OF BENEFITS

Definitions

The term “plan” means any plan shown below that provides medical expense benefits or services. However, if separate contracts are used to provide coordinated coverage for individuals within a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. The term “plan” includes

a. Group insurance, closed panel or other forms of group-type coverage (whether insured or uninsured). Group-type coverage that is not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group.

b. Medical care components of group long-term care contracts, such as skilled nursing care.

c. Medical Benefits under group or individual automobile contracts.

d. Medicare or other governmental benefits, as permitted by law.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan. Benefits payable under another plan include the benefits that would have been payable if claim had been made for them.

Allowable Expense means a health care service or expense, including applicable deductibles and co-payments that are at least partly covered under at least one of the plans covering the individual for whom claim is made. When a plan provides benefits in the form of services rather than cash, the value of each service rendered will be considered to be both:

a. An Allowable Expense, and

b. A benefit paid.

The following are not considered Allowable Expenses:

a. The difference between the cost of a private hospital room and the cost of a semi-private hospital room unless the patient’s stay in a private room is Medically Necessary.

b. The amount of reduction when a Covered Person’s benefits are reduced under a primary plan because a Covered Person:

- Has not complied with the Plan provisions concerning second surgical opinions or pre-certification of Hospital admissions, or
- Has a lower benefit because he or she did not use a preferred provider.
- Any amount in excess of the higher of the Maximum Eligible Charges or the amount payable to a PPO Provider if an individual is covered by two (2) or more plans that provide benefits or services on the same basis.
- Any amount in excess of the primary plan’s payments and arrangements.
- An expense or service that is not covered by any of the plans.

EFFECTS ON BENEFITS

The benefit payable under This Plan shall be integrated with the benefit payable for a Covered Person under all other plans. This Plan will: (1) determine the amount of benefits it would have paid had it been the person's only coverage (with the exception that This Plan will base its determination of Allowable Expenses upon the greatest PPO provider discount among all plans of the Covered Person for the same charges); (2) subtract the amount of benefits payable by other plans that determine benefits before This Plan; and (3) pay the difference, if any. If the other plans that determine benefits before This Plan pay as much as, or more than, This Plan would have paid had it been the person's only coverage (except as described above in regards to PPO provider discounts), then This Plan will not pay any benefits.

When This Plan's PPO negotiates a specific COB provision with a particular participating provider The plan's normal COB provision will be superceded by the PPO's COB provision.

ORDER OF BENEFITS DETERMINATION

The rules for deciding which plan determines benefits first are:

a. The benefits of a plan that has no rules for coordination with other benefits are determined before This Plan's benefits.

b. The benefits of a plan that covers the person as an employee, member or subscriber, that is, other than a dependent, are determined before those of the plan that covers the person as a dependent.

c. Except as stated below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":

- the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
- but if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
- however, if the other plan has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- first, the plan of the parent with custody of the child;
- then, the plan of the spouse of the parent with the custody of the child; and
- finally, the plan of the parent not having custody of the child.
- However, if a court decree states that one of the parents is financially responsible for the health care expenses, the benefits of that plan are determined first.

d. If a person whose coverage is provided under a right of continuation pursuant to Federal or state law is also covered under another plan, benefits for such person are determined in this order:

- first, the benefits of the plan covering the person as an employee, member or subscriber (or as that person's dependent);
- second, the benefits under the continuation coverage.
- 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 does not apply.

- If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

COORDINATION WITH COVERAGE FOR OUTPATIENT PRESCRIPTION DRUGS

The **"Effects On Benefits"** provision under the **"COORDINATION OF BENEFITS"** section of This Plan **does not apply** to outpatient prescription drugs obtained through the Prescription Drug Program of This Plan or the Prescription Drug Program, or Medical Benefit Coverage of any other plan that determines its benefits before This Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Claims Administrator may release or obtain any information if it is deemed necessary to implement this section or if it is deemed necessary for similar sections of other plans. Such information does not require prior notice or consent. Any person who claims benefits under This Plan shall give the Claims Administrator any necessary information required.

FACILITY OF PAYMENT

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plans, the Claims Administrator reserves the right to decide whether or not to reimburse the organization making the payment and the amount to be paid in order to satisfy the intent of this provision. Any such payment made will fulfill the Plan Sponsor's responsibility to the extent of such payment.

RIGHT OF RECOVERY

If the Claims Administrator makes an overpayment because of this or a similar section, the Claims Administrator has the right to recover the excess amount from any of the following sources: any person to whom payments are made, any plan, any other insurance companies, or any other organizations.

MEDICARE SECONDARY PROVISIONS

Coverage at Age 65 for Active Employees and Dependent Spouses

If an active employee covered by This Plan is age **65** or older and has Medicare Part A, This Plan is the primary payer and Medicare is the secondary payer of benefits provided under both This Plan and Medicare Part A or B. The same applies to a covered spouse if the spouse of an active employee is age **65** or over and has Medicare Part A, or if the spouse is employed and is age **65** or over and has Medicare Part A.

Benefit Determination When Medicare is Primary

When a Covered Person is eligible for Medicare, Medicare will pay primary, secondary or last to the extent stated in Federal law. When Medicare is the primary payer, This Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Coverage Options at Age 65

This Plan as the Employee's primary coverage and Medicare as the Employee's secondary coverage means that the covered Employee or Dependent spouse continue to submit all claims to this Plan and receive the same benefits as any younger Employee or Dependent spouse. Medicare would then consider a claim for any remaining expenses.

Medicare alone – the covered Employee or Dependent spouse may choose not to participate in this Plan and have Medicare as their only health coverage. In this case, claims could only be submitted to Medicare. (Medicare has certain deductible and co-payments for most services as well as premiums to be paid for Part B coverage.)

If the covered employee elects Medicare as the primary health coverage, the Dependent spouse may not continue, at age 65, to be covered under this Plan, even if otherwise eligible (see COBRA section).

Coordination of Benefits with Medicare

FOR ELIGIBLE EMPLOYEES OR DEPENDENTS WHO HAVE COVERAGE UNDER THIS PLAN DUE TO ACTIVE EMPLOYMENT STATUS AND MEDICARE COVERAGE DUE TO DISABILITY.

If a covered Employee or his/her Dependent is under age 65 and covered under Medicare due to disability (other than end-stage renal disease or the need for kidney dialysis or a kidney transplant), this Plan will pay its benefits before Medicare if the Plan is considered to be a Large Group Health Plan.

If a covered Employee or his/her Dependent is under age 65 and covered under Medicare due to disability (other than end-stage renal disease or the need for kidney dialysis or a kidney transplant), this Plan will pay its benefits after Medicare if the Plan is not considered to be a Large Group Health Plan.

For purposes of this provision, the following terms shall have the following meanings:

a. **Disabled Employee or Dependent** means an individual, under age 65, who is eligible for Medicare Part A benefits due to disability as defined and determined by the Social Security Administration.

b. **Large Group Health Plan** means a plan that covers employees of an employer that normally employed at least 100 employees on a typical business day during the previous Calendar Year.

FOR ELIGIBLE EMPLOYEES OR DEPENDENTS WHO HAVE COVERAGE UNDER THIS PLAN DUE TO ACTIVE EMPLOYMENT STATUS AND MEDICARE COVERAGE DUE TO END-STAGE RENAL DISEASE OR A KIDNEY TRANSPLANT.

If a covered Employee or his/her Dependent is under age 65 and on or after February 1996, becomes eligible for or covered under Medicare due to end-stage renal disease or the need for kidney dialysis or a kidney transplant, this Plan will pay its benefits before Medicare during a 30-month coordination period.

If, during the 30-month coordination period, the covered Employee or his/her Dependent subsequently becomes covered under Medicare due to age or disability (other than end-stage renal disease or the need for kidney dialysis or a kidney transplant), this Plan will continue to pay its benefits before Medicare for the duration of the 30-month coordination period.

If a covered Employee or his/her Dependent simultaneously become eligible for or covered under Medicare due to end-stage renal disease or the need for kidney dialysis or a kidney transplant as well as eligible for or covered under Medicare due to age or another disability, this Plan will pay its benefits before Medicare during a 30-month coordination period.

Medicaid Provisions

Rights Of States With Respect To Group Health Plans Where Employees Thereunder Are Eligible For Medicaid Benefits

The Plan shall provide that payment of benefits with respect to a Covered Employee or Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Employee or Dependent as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1921(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

Enrollment And Provision Of Benefits Without Regard To Medicaid Eligibility

The Plan shall provide that, in enrolling an individual as an Employee or Dependent, or in determining or making any payments of benefits for such Employee or Dependent, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

Acquisition By States Of Rights Of Third Parties

This Plan shall provide that, to the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act, in any case in which the Plan has a legal liability to make payment for items or services constitutes such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Covered Employee or Dependent to such payment for such items or services. However, if the Plan has paid benefits to a Provider for or on behalf of a Covered Person and a state medical assistance plan also provides benefits for the same drugs, services, devices, procedures or treatments by the same Provider, then the Plan shall have no liability to the state medical assistance plan.

Special Provisions with Respect to Medicare

In accordance with the Medicare Secondary Payor Act, as amended, an active Employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under This Plan. If such person elects coverage under This Plan, the benefits of This Plan shall generally be determined before any benefits provided by Medicare. However, whenever This Plan may lawfully assume a secondary position, it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When This Plan may lawfully assume a secondary position and an Employee or Dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under This Plan. An Employee or Dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner.

SUBROGATION AND REIMBURSMENT

This Plan is designed to provide Covered Persons with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any payments or benefits a Covered Person has or may recover when charges are Incurred as the result of an Accident, Illness, Injury or other medical condition caused by an act or omission of any Other Party. Benefits under this Plan are reduced or excluded subject to the terms and conditions of this Subrogation, Reimbursement and Offset Provision anytime there is an Other Party who is liable or responsible (legally or voluntarily) to make payments in relation to the Accident, Illness or Injury.

DEFINITIONS

The following definitions will apply only to this section:

"Accident" means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

"Injury" means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

"Other Party" is defined to include, but is not limited to, the following:

- the party or parties that caused the Accident, Illness, Injury or other medical condition;
- the insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- the Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment, no-fault insurers or home-owner's insurance;
- a worker's compensation or school insurer;
- any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

"Recovery" is defined to include, but is not limited to, any amount paid or payable by an Other Party through a settlement, judgment, mediation, arbitration, or other means in connection with an Accident, Injury or Illness.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Sickness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Sickness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

a. Execute and deliver a Subrogation and Reimbursement Agreement provided by the Plan Administrator;

b. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

c. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

d. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

e. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

f. When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

g. The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

Another Party

Another Party shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

Another Party shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

Recovery

Recovery shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Subrogation
Subrogation shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Reimbursement
Reimbursement shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

ELIGIBLITY, EFFECTIVE DATES AND TERMINATION OF COVERAGE

Eligibility Requirements — Employees
"Employee" shall mean all elected officials and all active regular full-time employees who are regularly scheduled to work an average of 30 or more hours per week who are in an eligible class for Employee and Dependent Coverage.

Employees, and their spouses who meet the requirement of Retirement or Early Retirement (until attainment of age 65) under the plan are also eligible to participate in the plan. In order to be eligible for retiree coverage an active employee who meets the definition of an eligible retiree must apply for coverage within 31 days of the date of retirement. Coverage will be effective for employee and any covered eligible dependents on the date they are no longer eligible to participate as an active employee. Covered dependents under the age of 65 may continue coverage under the County's medical, dental, vision, and prescription plans after the retiree reaches age 65 or in the event of the retiree's death.

The following classes of Employees are not eligible for coverage:

- Temporary Employees
- Part-time Employees
- Contract Employees
- Employees who reside outside of the United States, unless on temporary assignment for a period not to exceed twelve (12) months.

An Employee (except for elected officials) becomes eligible for participation in the Plan on the first day of the month following 30 days of employment provided the Employee submits an enrollment form within thirty-one calendar days of his Eligibility Date and authorizes payroll deductions for any required contributions to the Plan. Elected officials become eligible for coverage on their hire date, provided the Employee submits an enrollment form within thirty-one calendar days of his Eligibility Date and authorizes payroll deductions for any required contributions to the Plan.

Employee shall be deemed to be in full-time employment for purposes of accruing the 30 day waiting period, even if the Employee is absent from work due to a health factor. However, in order to be eligible to participate in the Plan, the Employee must begin work for his Employer. If the Employee is not actively at work on the scheduled effective date of coverage (for reasons other than minor illness or injury), then coverage will become effective on the first of the following month after the Employee actually returns to work.

An employee previously covered under this Plan whose coverage ceases due to lay-off, termination of employment, or whose coverage lapses from non-payment of any required contribution, or an employee returning to work directly from coverage under the Plan's COBRA continuation option for himself and any previously covered eligible Dependents, and who is rehired within 30 days and becomes an eligible Employee shall become eligible for coverage again, in accordance with the following provisions:

a. Such persons shall be reinstated on the date rehired as if no interruption in coverage occurred, not subject to a new Waiting Period, Calendar Year Deductible or Out-of-Pocket Maximum, within that Calendar Year, but with any expenses incurred and applied toward the Calendar Year Deductible and Out-of-Pocket Maximum applied when coverage resumes.

b. Any expenses incurred and applied toward the Plan's specified Maximums prior to cessation of coverage will apply when coverage resumes.

Ongoing Eligibility
In order to be an "Eligible Employee," so that he is eligible to participate in coverage provided under the Plan, an Employee must average 30 or more hours per week during a prior 12 month "measurement period". This measurement period runs from [October 1st to September 30th] of each year. Those Employees who average 30 or more hours per week over this 12-month measurement period will be eligible for coverage effective as of the first day of the Plan Year next following the end of the measurement period, and will remain Eligible Employees

for the entire Plan Year regardless of the number of hours actually worked during such Plan Year. However, coverage may end for other reasons, as described in the Termination of Coverage section of this Plan.

Initial Measurement Period
Upon hire if the Employer can not determine whether the Employee is reasonably expected to average at least 30 hours per week because the Employee's hours are variable or otherwise uncertain (*i.e.,* the Employee is a "variable hour" Employee), or if the Employee is a "seasonal" Employee, the Employee will be subject to an "initial measurement period" to determine eligibility for coverage under the Plan. The "initial measurement period" will begin on the [first day of the month next following the date of hire] and will last for 12 months. If the Employee averages 30 or more hours per week over the initial measurement period, the Employee will be an Eligible Employee who is eligible for coverage under the Plan. Such coverage will be effective on the first day of the month next following a one-month administrative period after the end of the initial measurement period. The Employee will remain an Eligible Employee for 12 months regardless of the number of hours worked during such 12 months; however, coverage may end for other reasons, as described in the Termination of Coverage section of this Plan.

Effective Date — Employees

This Plan provides contributory coverage (each Employee pays a part of the cost of his own coverage). An Eligible Employee's coverage is effective, subject to conditions set forth above, upon completion of the forms provided by the Contract Administrator for such purpose.

If an Employee fails to enroll within 31 days of completion of the Waiting Period, the Employee's coverage will be effective only if enrolled under the special enrollment provision or if enrolled during an annual enrollment.

Eligibility Requirements — Dependents
If an Employee is covered by the Plan, the Employee's Eligible Dependents can also be covered. An "Eligible Dependent" is:

a. a lawful spouse who is not divorced or legally separated. Such spouse must have met all requirements of a valid marriage contract in the state of Texas;

b. any child under the age of 26 (including any natural child, any legally adopted child or a child placed for adoption with Employee; a stepchild; a foster child or grandchild if obtained by legal custody).

An "Eligible Dependent" does not include:

a. a spouse, if they are eligible for coverage offered to them through their own employer;

b. any person who is on active duty in a military service;

c. any person who resides outside of the United States;

d. any person who is eligible as an Employee under the Plan; or

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

Additional Conditions
No Dependent coverage will be effective under the Plan unless the Employee is, or simultaneously becomes covered under the plan.

Benefits payable on behalf of a Dependent previously covered under the Plan as an Employee shall not exceed the maximum benefits that would have been payable during such period had the Dependent remained covered as an Employee.

Benefits payable on behalf of an Employee previously covered under the Plan as a Dependent shall not exceed the maximum benefits that would have been payable during such period had the Employee remained covered as a Dependent.

Benefits payable on behalf of an Employee or Dependent covered under the Plan, whose coverage under the Plan is terminated due to termination of the Employee's employment or a reduction in hours and reinstated when the Employee is rehired or the Employee's hours are increased at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of the Employee's employment.

Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" (QMCSO) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

A QMCSO is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

a. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

b. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

c. The period of coverage to which the order pertains; and

d. The name of this Plan.

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

Medical Child Support Order shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

a. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

b. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

a. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

b. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

National Medical Support Notice (NMSN)
In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

a. Contains the information set forth above in the definition of "National Medical Support Notice";

b. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or

c. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

d. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

National Medical Support Notice shall mean a notice that contains the following information:

a. Name of an issuing state agency;

b. Name and mailing address (if any) of an employee who is a Participant under the Plan;

c. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

d. Identification of an underlying child support order.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

a. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

   - Whether the child is covered under the Plan; and

   - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

   - Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

b. To give effect to this requirement, the Plan Administrator shall:

   - Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

   - Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Effective Date — Dependents
Subject to the Plan's special enrollment provisions, an Eligible Dependent will be covered the date the Employee's coverage begins, provided the Employee makes written application for coverage for such Dependent in a form furnished by the Plan Administrator or Contract Administrator for that purpose within 31 days of Dependent's initial eligibility and the Employee has agreed to pay any required contribution for such coverage:

Any change in a Dependent's coverage will not become effective until the change in the Employee's coverage also has become effective.

If an Employee fails to enroll Dependents within 31 days of completion of the Waiting Period, the Dependents coverage will be effective only if enrolled under the special enrollment provision or if enrolled during an annual enrollment.

Special Enrollment
If an Eligible Employee does not enroll for coverage for the Employee and/or the Employee's Eligible Dependents within thirty-one (31) days of becoming eligible for coverage and subsequently wishes to elect such coverage, the Employee may only do so under the Plan's special enrollment rules under certain circumstances as follows:

a. Special Enrollment for Qualifying Events - Section 125 of the Internal Revenue Code (IRC) defines certain family status changes that qualify an Employee to modify their benefit elections. Anytime during the plan year, when a qualifying family status change occurs, an employee may modify their benefit elections within 31 days of the qualifying event.

b. Qualifying events include, but are not limited to, marriage, divorce, death, change in factors effecting benefit elections including a substantial change in the plan of benefits or required contribution, or loss of eligibility for alternative coverage, because either (i) it was COBRA continuation coverage that has been exhausted, or (ii) eligibility for the alternative coverage was lost (for reasons other than the individual's failure to pay premiums or for cause), (iii) termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility, (iv) employee or dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance, (v) or employer contributions toward the cost of the coverage terminated. In this case, the Employee must submit a completed enrollment form within 30 days after the date on which (1) COBRA continuation coverage was exhausted, or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage.

c. For an employee with one or more eligible dependents (other than a spouse), a new birth, adoption, or placement for adoption will not be considered a Special Enrollment Qualifying Event.

Effective Dates for Special Enrollment Resulting from a Qualifying Event

a. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage (i.e., Spouse or Child or Children); (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

b. The effective date for a Dependent child who is adopted or acquired through marriage under this provision is (a) the date shown in the court order of adoption for a Child, (b) the date the child is placed with the Employee for adoption, or (c) the date the Child is acquired as a result of marriage.

c. Enrollment in the Plan will be effective the first day following a change in factors effecting benefit elections including a substantial change in the plan of benefits or required contribution, or loss of eligibility for alternative coverage,

d. The Employee must submit a completed enrollment form within 31 days of the Qualifying Event and authorize payroll deductions for any required contributions to the plan.

Annual Enrollment
During the annual enrollment period, Eligible Employees who have not previously enrolled for coverage for the Employee and/or eligible dependents (within 31 days of becoming eligible for coverage) may enroll for 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 shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an Employee or as a Dependent of the terminated Employee.

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

a. the date of termination of the Plan;

b. the date of termination of participation in the Plan by the Employee;

c. the day prior to the date of Employee's entry into the armed forces of any country;

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

e. the date on which the covered Employee leaves or is dismissed from the employment of the Employer;

f. the date the Employee ceases to be eligible for coverage under the Plan; and

g. immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including Enrollment information.

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

a. the date of termination of the Plan;

b. the date coverage for Dependents terminates under the Plan;

c. the date the Employee ceases to be in a class of Employees who are eligible for Dependent Coverage;

d. the date the Dependent becomes covered as an Employee under the Plan;

e. the date of termination of the coverage of the Employee;

f. the date the Covered Person no longer satisfies the Plan's definition of Dependent;

g. the date of expiration of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (the Employee shares in the cost); or

h. immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

EXTENSION OF COVERAGE

Extension of Coverage for Handicapped Dependent Children
(Available during the continuance of the Plan only)

If an already covered Dependent Child attains the age that would otherwise terminate his status as a Dependent, and:

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

b. at the time of attainment of such age, the child is incapable of self-sustaining employment by reason of mental retardation, physical handicap, or disability that commenced prior to the attainment of such age, and

c. such child is dependent upon the Employee for at least fifty percent (50%) of his or her support and maintenance within the meaning of the Internal Revenue Code as it may be periodically amended, and is/are reported as a dependent on the Employee's current Internal Revenue Service Tax Statement,

then such child's status as a Dependent shall not terminate solely by reason of his having attained the specified age, and he shall 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 a Dependent.

The Employee must submit to the Contract Administrator proof of the child's incapacity within 30 days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage During Absence From Work
(Available during the continuance of the Plan only)

If an Employee fails to continue in active employment for any of the following reasons, but not limited to sickness, injury, maternity leave, temporary layoff, entry into the armed forces, or approved leave of absence, the Employee may be permitted to continue health care coverage for himself and his Dependents, though Employee could be required to pay the full cost of coverage during such absence. However, in no event can the extension under this provision be longer than 12 months.

Any such extended coverage offered by the Plan and elected by the Employee shall automatically and immediately cease on the earliest of the following dates:

a. the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this Plan;

b. the date of expiration of the period for which the last contribution was paid, if such contribution is required; or

c. the date and time of termination of this Plan.

This Plan is intended to conform to the applicable provisions of the Family Medical Leave Act of 1993 as outlined below.

Family and Medical Leave Act of 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

B. Reasons for FMLA Leave

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.

2. The placement of a son or daughter with you for adoption or foster care.

3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.

4. Because of a serious health condition that makes you unable to perform the functions of your position.

5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:

    a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and

    b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member's office, grade, rank, or rating.

6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

CONTINUATION OF COVERAGE OPTION (COBRA)

This option does not apply to participants whose employers have fewer than 20 employees, in accordance with federal law.

In order to comply with COBRA, the Plan includes a continuation of coverage option that is available to certain Covered Persons whose health care coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law and its amendments, the law will prevail.

Definitions

Qualified Beneficiary
Qualified Beneficiary is an Employee who was covered by the Plan on the day before the Qualifying Event or an Employee's Dependent who was covered by the Plan on the day before the Qualifying Event, or a child who is born to, or placed for adoption with, a covered Employee during continuation coverage.

Qualifying Event
Qualifying Event shall mean any one of the following that would result in the loss of coverage under the Plan: the death of the covered Employee, the termination of the covered Employee (other than by the Employee's gross misconduct), reduction in a covered Employee's hours of employment to an ineligible status, the divorce or legal separation of the covered Employee from the Employee's spouse, the Employee's coverage termination due to Medicare entitlement, or the cessation of covered Dependent child coverage by operation of a plan provision.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed 36 months (except for certain circumstances under COBRA's special bankruptcy rules for retirees and their Dependents).

Notification

Employees must notify the employer or contract administrator within 60 days of a qualifying event in event of divorce, legal separation, or dependent child becoming ineligible. Qualified beneficiaries must notify the employer or contract administrator within 60 days of a qualifying event or secondary qualifying event in event of divorce, legal separation, or dependent child becoming ineligible.

The Plan Administrator must notify Qualified Beneficiaries of continuation of coverage rights in the event of the Employee's death, termination, reduction of hours, or entitlement to Medicare. Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to a spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made. Notification must be made to Qualified Beneficiaries within 44 days of the Plan Administrator's notice of the occurrence of a Qualifying Event.

Election and Election Period

Continuation of coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

- 60 days after coverage ends due to a Qualifying Event; and
- 60 days after the Qualified Beneficiary receives notice of the continuation of coverage option rights.

If continued coverage is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries who would otherwise lose coverage. However, each individual who would otherwise lose coverage is entitled to make an individual election that would allow one to elect continued coverage even if others in the same family have declined, or, if optional benefits were available, an Eligible Employee and his Dependents could elect different coverage.

Effective Date of Coverage

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 Qualified Beneficiary will be retroactively charged for coverage accordingly.

Level of Benefits

Continuation coverage hereunder will be equivalent to coverage provided to a similarly situated Covered Person to whom a Qualifying Event has not occurred. If coverage of similarly situated Covered Persons is modified, the same modification shall apply to Qualified Beneficiaries.

Cost of Continuation of Coverage

Except as provided below, the cost of coverage may be paid in monthly installments, and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of election of continuation of coverage hereunder. Thereafter, payments are due on the 1st day of each month to continue coverage for that month. If a payment is not made within 30 days of the due date, coverage will be cancelled and will not be reinstated. The cost of coverage is subject to change each Plan year.

Termination of Continuation of Coverage

Coverage under this provision will terminate on the occurrence of the earlier of:

a. the end of 36 months, if the Qualifying Event is the death of the covered Employee, divorce or separation, Employee's entitlement to Medicare, or a Dependent child who no longer qualifies as a Dependent;

b. at the end of 18 months, if the Qualifying Event is termination of employment or reduction of hours to an ineligible status. However, in the case of a Qualified Beneficiary who is determined under the Social Security Act ("the Act") to have been totally disabled within 60 days of such Qualifying Event, the Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the continuation coverage) for a total of 29 months provided the Qualified Beneficiary notifies the Plan Administrator of the disability prior to the end of the 18 months of continuation coverage, and within 60 days of the determination of total disability under the Act. The cost for continuation coverage for months 19 through 29 will not exceed 150% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Further, if during continuation coverage months 19-29, the Qualified Beneficiary is finally determined under the Act not to be Totally Disabled, then the Qualified Beneficiary shall within 30 days notify the Plan Administrator, and continuation coverage shall terminate the last day of the month following 30 days after the date of the determination;

c. the termination of all group health plans provided by the Plan Sponsor;

d. the failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is more than 30 days delinquent in paying his premium);

e. the date the Qualified Beneficiary is covered under any other group health plan, as a result of employment, re-employment, or remarriage, that does not have a pre-existing condition that applies to the Qualifying Beneficiary; and

f. the date the Qualified Beneficiary becomes entitled to Medicare benefits.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, keep the employer or contract administrator informed of any changes in addresses of you or your family members.

Certificates of Coverage

The Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan. Such certificates will be provided within the following time frames:

a. for an individual who is a Qualified Beneficiary entitled to elect continuation coverage, no later than when a notice is required to be provided for a Qualifying Event, as set forth above;

b. for an individual who is not a Qualified Beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and

c. for an individual who is a Qualified Beneficiary and who has elected continuation coverage, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under this provision.

WHAT ARE THE QUALIFYING EVENTS?

QUALIFIED BENEFICIARY	QUALIFYING EVENT	MAXIMUM LENGTH OF COVERAGE
Employee and/or Covered Dependent(s)	1. Voluntary or involuntary termination of employment (except for gross misconduct), including retirement. 2. Reduction of hours	18 months
Disabled* Employee and/or Disabled Covered Dependent(s)	1. Voluntary or involuntary termination of employment (except for gross misconduct), including retirement. 2. Reduction of hours.	29 months
Covered Dependent(s)	1. Death of employee. 2. Divorce or legal separation. 3. Dependent child ceases to qualify as a dependent under the Plan (limiting age). 4. Active employee becomes entitled to Medicare	36 months

*A qualified beneficiary is considered disabled if he or she has been determined to be disabled (under Title II or XVI of the Social Security Act) at the time of the qualifying event. The qualified beneficiary must notify the Plan Administrator within 60 days of the determination and before the end of the 18-month continuation.

In case of multiple qualifying events, the maximum continuation for dependents will be 36 months.

CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE

The procedures outlined below must be followed by Claimants to obtain payment of health benefits under this Plan.

Important Definitions
The following defined terms are used in this Claims Procedures section:

"Adverse Benefit Determination" means any of the following: (1) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Covered Person's eligibility to participate in the Plan; (2) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures; (3) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; or (4) a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

"Adverse Benefit Determination on Review" means the upholding or affirmation of an appealed Adverse Benefit Determination.

"Benefit Determination" means a determination by the Plan Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

"Benefit Determination on Review" means a determination by the Plan Administrator on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

"Claimant" means a Covered Person under the Plan, or his authorized representative or health care provider, who is designated by the Covered Person to act on his behalf.

"External Review" means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the Federal External Review process described in this Claims Procedures section.

"Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules).

"Independent Review Organization" or "IRO" means an entity that conducts independent External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations.

Health Claims
All claims and questions regarding health claims should be directed to the Contract Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Contract Administrator; provided, however, that the Contract Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that

the Claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service Non-urgent, Concurrent Care and Post-service.

Pre-Service Claims
A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Claimant needs medical care for a condition, which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Claimant should obtain such care without delay.

Further, since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no "Pre-service Urgent Care Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims
A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

It is important to remember that, in the event of an urgent care situation, the Covered Person need only notify CHR on the first business day after the additional stay begins. Since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims
A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed
Health claims must be filed with the Contract Administrator within 12 months from the date on which Covered Expenses were incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more

information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the timeframes described under each type of claim listed below.

Pre-service Non-urgent Care Claims
If the Claimant has provided all of the information needed to process the claim, the Claimant will be notified in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

Concurrent Claims Plan Notice of Reduction or Termination.
If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, then the Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Request by Claimant Involving Non-urgent Care
If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims
If the Claimant has provided all of the information needed to process the claim, the Claimant will be notified in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

Extensions – Pre-service Non-urgent Care Claims
This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims
This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods
The period of time within which a Benefit Determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically containing the following information:

1. The specific reason or reasons for the Adverse Benefit Determination;
2. Reference to the specific Plan provisions upon which the determination is based;
3. A description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures and time limits applicable to such procedures. If the Adverse Benefit Determination is based upon:
   a. An internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
   b. A medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
5. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
6. The reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;
7. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and
8. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

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Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims
In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. A Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination and 60 days to appeal a Adverse Benefit Determination on Review;
2. Claimants have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior Benefit Determination;
5. Each Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;
6. Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date;

7. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
8. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
9. That a Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Contract Administrator.

First Appeal Level

Requirements for First Appeal
The Claimant must file the first appeal in writing within 180 days following receipt of the notice of an Adverse Benefit Determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows: Pre-service Non-urgent Claims – Boon-Chapman 972-772-6097 or Post-service Claims – Boon Chapman Benefit Administrators, Inc., Attention: Appeals, P.O. Box 1749, Rockwall, Texas 75087 Fax Number: 972-772-6097.

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories, which support this claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal
The Plan Administrator shall notify the Claimant of the Plan's Benefit Determination on Review within the following timeframes:

Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

Concurrent Care Claims
The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims
Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal.
The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on Review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. 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 Claimant's claim for benefits;
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
5. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
6. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency";
7. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
8. The reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefits Determination including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;
9. A description of available internal appeals and External Review processes, including information regarding how to initiate an appeal; and
10. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan Administrator shall notify the Claimant of the Plan's Benefit Determination on Review within the following timeframes:

Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Care Claims
The response will be made in the appropriate time period based upon the type of claim – Pre-service Urgent, Pre-service Non-urgent or Post-service.

Post-service Claims
Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

External Review
In accordance with the U.S. Department of Labor Technical Release 2010-01, the Plan will comply with the safe harbor for non-grandfathered self-funded group health plans not subject to a State External Review process, and therefore subject to the Federal External Review process, until superseded by future guidance. External Review will be available with respect to claims for medical benefits. However, a claim for dental benefits or a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet eligibility requirements under the Plan is not eligible for External Review.

1. **Request for Standard External Review**. A Claimant shall have four (4) months from the receipt of the notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination to submit a written request an External Review to the Plan Administrator.

2. **Preliminary Determination**. Within five (5) business days of receipt of a request for an External Review, the Plan Administrator shall complete a preliminary review of the request to determine whether:

    a. The Claimant is or was covered by the Plan at the time the health care item or service in question was requested or provided, or that the health care item or service was covered under the Plan at the time the health care item or service was provided;

    b. The Final Internal Adverse Benefit Determination does not relate to whether the Claimant satisfied the eligibility requirements of the Plan;

    c. The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeal process under 29 C.F.R. § 2590.715-2719; and

    d. The Claimant has provided all the information and forms required to process an External Review.

3. **Preliminary Notice**. If a request is not eligible for External Review, the Plan Administrator must issue a written notice to the Claimant within one (1) business day after the Plan Administrator completes the preliminary review, which must include the reasons the requested appeal is not eligible for External Review and contact information for the Employee Benefit Security Administration. If a request is not eligible for External Review because it is incomplete, the notice must include a description of the information necessary to complete the request and permit the Claimant to submit such information by the later of 48 hours after the Claimant receives the notice or by the end of the four (4) month period during which the External Review must be requested.

4. **Standard External Review**. If a claim is eligible for External Review, the Plan will assign the claim to an IRO that is one of at least three IROs retained by the Plan to conduct External Reviews and which is due to receive the claim on the Plan's rotational basis established to ensure independence. The external IRO will conduct a full review of the file, applicable Plan provisions and any material submitted as required by applicable guidance and in compliance with the IRO's contract with the Plan. The IRO will conduct this review on a de novo basis without deference to the Plan's decision.

    Within five business (5) days after the Plan has assigned an IRO to review the claim, the Plan shall provide the documents and information considered by the Plan in making its Final Internal Adverse Benefit Determination. If the IRO receives any new evidence or information, it shall provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the Claimant and the IRO of its new decision within one (1) business day of making such decision. The IRO must then terminate its review.

    The IRO shall provide the Claimant and the Plan with a written notice of its decision within 45 days of the date on which the IRO received the request for External Review. Such notice shall include all information required by applicable guidance.

    Upon receipt of the IRO's final determination reversing the Plan's determination, the Plan shall immediately provide coverage or payment for the claim.

5. **Expedited External Review**. An expedited External Review shall be provided:

   a. If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

   b. If the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged since receiving such emergency services.

   Upon receipt of a request for an expedited External Review, the Plan shall determine if the request satisfies the requirements to be eligible for a standard External Review. The Plan must immediately send the Claimant a notice of such preliminary determination of eligibility.

   If a claim is eligible for expedited External Review, the Plan shall assign the claim to an IRO. The IRO shall provide the Claimant and the Plan with a written notice of its decision as soon as possible, but in no event more than 72 hours after the IRO received the request for an expedited External Review. If the notice is not in writing, within 48 hours of the date the notice is provided, the IRO must provide a written confirmation of its decision to the Claimant and the Plan.

Exhaustion of Administrative Remedies
No action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted. If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review under the Plan. The denial of the claim will become final and binding on all persons for all purposes.

If the Plan fails to strictly adhere to all the requirements of the Claims Procedures with respect to a claim, the Claimant is deemed to have exhausted the internal claims and appeals process. In such case, the Claimant may initiate an External Review.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative
A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

Unclaimed Benefits
If, within twelve (12) months after any amount becomes payable hereunder to a Covered Person or Beneficiary, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments, the amount thereof will be forfeited and will cease to be a liability of the Plan.

DEFINITIONS

When used in this Plan Document, the following items shall have the meanings shown below. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

Accidental Injury
Any accidental bodily Injury that occurs while an individual is covered under the Plan and that is caused by external forces under unexpected circumstances and that does not arise out of or in the course of the employment of the Covered Person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching are not considered Accidental Injuries.

Active Course of Orthodontic Treatment
The period of time which begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

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

Alternate Recipient
Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent.

Ambulatory Surgical Center
An institution or facility, either free standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a 24-hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

Birthing Center
A special room in a Hospital that exists to provide delivery, prenatal, and postnatal care with a minimum of medical intervention, or a free-standing out-patient facility that:

a. is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

b. is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

c. has organized facilities for birth services on its premises; and

d. provides birth services by Physicians, licensed registered graduate nurses (R.N.s), or midwife nurse practitioners when a patient is in the center.

BMI
Body mass index, a number that shows body weight adjusted for height.

Calendar Year
The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:00 midnight on the next December 31. Each succeeding like period will be considered a new Calendar Year.

Calendar Year Maximum Benefit
The most benefits the Plan will pay for Covered Expenses of a Covered Person Incurred during a Calendar Year.

Certificate of Coverage
A written certification provided by any source that offers medical care coverage, including this Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Claimant
Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides for continuing coverage for eligible terminated employees.

Co-insurance
See the Schedule of Benefits.

Contract Administrator
The company that provides claims adjudication and other administrative services to the Plan in accordance with an administrative services agreement between the Contract Administrator and the Employer.

Co-payment or Co-pay
The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible or the Annual Out-of-Pocket Maximums.

Covered Expense
An expense incurred by a Covered Person that is payable by the Plan as Co-insurance or is payable by the Covered Person as a deductible, as Co-insurance, as a Co-payment, or because of a benefit.

Covered Person
A covered Employee, a covered Retiree, a covered Dependent, or a COBRA Qualified Beneficiary.

Creditable Coverage
Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

Custodial Care
The term "Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, and preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible
After In-Network first dollar benefits are depleted the amount of Covered Expenses the Employee or Dependent must incur and pay each Calendar Year before benefits are payable under the Plan. The Deductible amount is shown in the Schedule of Benefits. PPO Deductibles do cross apply. Both the PPO and Non-PPO Deductibles will be considered in determining whether a Covered Person has satisfied the Deductible under the Plan.

Dental Hygienist
A person who is licensed to practice dental hygiene, practicing within the scope of his or her license, and not a member of your Immediate Family.

Dental Practitioner
A Dentist, Dental Hygienist, or Denturist.

Dentist
A person who is licensed to practice dentistry or Oral Surgery, practicing within the scope of his or her license, and not a member of your Immediate Family.

Denturist
A person who is licensed to make, fit, or repair dentures, practicing within the scope of his or her license, and not a member of your Immediate Family.

Dependent
See "Eligibility and Effective Dates."

Durable Medical Equipment
Durable Medical Equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

a. can withstand repeated use;

b. are primarily and customarily used to serve a medical purpose;

c. generally are not useful to a person in the absence of Sickness or Accidental Injury; and

d. are appropriate for use in the home.

Hearing aids are also Covered under Durable Medical Equipment

Emergency Care
Services provided to a Covered Person on an inpatient or outpatient basis which, if not provided, would jeopardize the health or life of that Covered Person.

Employee
See "Eligibility and Effective Dates."

Employer
The entities listed in "Administrative Information" as participating employers.

Enroll/ Enrollment
The act of completing and submitting an application for coverage to the County.

Essential Health Benefits
Includes (1) ambulatory services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care, as determined by the Plan Administrator in accordance with the Affordable Care Act.

Generic Drug
A drug called by its chemical name. The brand name of the drug is given to it by its original developer and is registered and protected under U.S. Patent and Copyright laws. When the patent expires on a drug, a generic equivalent may be manufactured and sold as long as the Food and Drug Administration is satisfied that the Generic Drug will have the same effectiveness as the brand name.

Home Health Care
A program of continued care and treatment of a Covered Person after discharge from a Hospital. The care and treatment must be:

a. For the same or related condition requiring hospitalization,

b. An alternative to staying in the Hospital, and

c. Prescribed in writing by the attending Physician and beginning within seven (7) calendar days of discharge from the Hospital.

Home Health Care Agency
A public or private agency or organization that specializes in providing Home Health Care in the Covered Person's home. An agency or organization that:

a. is certified under Title 18 of the United States Social Security Act of 1965, as amended from time to time; or

b. is certified to participate as a home health care agency in the area in which the services are rendered.

c. Primarily provides nursing and other therapeutic services,

d. is associated with a professional group, which makes policy. This group must have at least one Physician and one registered graduate nurse,

e. Has full time supervision by a Physician or a registered graduate nurse,

f. Keeps complete medical records of each person,

g. Has a full time administrator, and

h. Meets applicable licensing standards, if any.

Hospice Care Program
An entity:

a. providing a coordinated set of services rendered at home, in an Outpatient setting, or in an institutional setting for Covered Persons suffering from a condition that has a terminal prognosis;

b. that has an interdisciplinary group of personnel including at least one Physician and one licensed registered graduate nurse (R.N.);

c. that maintains central clinical records on all patients; and

d. meets the standards of the National Hospice Organization and applicable state licensing requirements.

Hospital
An institution that:

a. complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

b. is primarily engaged in providing medical treatment to sick and injured persons as registered bed-patients;

c. has a staff of one or more licensed doctors of medicine or doctors of osteopathy available at all times;

d. continuously provides a 24-hour-a-day nursing service by licensed registered graduate nurses (R.N.s);

e. maintains facilities for diagnosis of Injury and disease;

f. maintains permanent facilities for major surgical operations on its premises; and

g. is not, other than incidentally, a place of rest, for Custodial Care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school, or a similar institution.

A Hospital will also include:

a. an institution that is legally constituted as a hospital and for which the laws of the state specify requirements other than those listed above and that is operated primarily for the care and treatment of sick and injured person as Inpatients;

b. an institution or facility that provides treatment for mental illness, provided that such institution or facility:

    - is licensed by the state licensing body or is approved by the state department responsible for such institutions or facilities; and renders recognized treatment for the condition for which it is licensed or approved to operate; or

c. an alcohol dependency treatment center that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

- affiliated with a Hospital under a contractual agreement with an established system for patient referral;
- accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
- licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Illness
A bodily disorder, disease, physical Sickness, mental infirmity, Serious Mental Illness, functional nervous disorder or Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Immediate Family
The Employee, Employee's spouse, and the children, brothers, sisters, and parents of Employee and spouse.

Incurred
Expenses shall be deemed to be "Incurred" on the latest of the following dates:

a. the date a purchase is contracted;

b. the date delivery is made; or

c. the actual date a service is rendered.

With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

With respect to dental services, expenses shall be deemed to be "Incurred" on the date that the service or treatment is performed, except for the following services or treatments:

a. dentures or bridgework – the date the impressions are taken;

b. crowns, inlays, onlays, - the date the teeth are first prepared;

c. root canal therapy – the date the pulp chamber is opened; and

d. active orthodontic care – the date the appliances are inserted.

Initial Eligibility
When an insured satisfies the waiting period and is first eligible to enroll in the group health plan.

Injury
A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient
A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) that 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.

Late Enrollee
An individual who is allowed to enroll in the Plan, other than during the period of initial eligibility or during a special enrollment eligibility period.

Maximum Eligible Charge
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 a commercial healthcare database;
- A fee determined using a percentage off of billed charges; or
- A fee determined using other relevant information.

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.

Medically Necessary or Medical Necessity
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:

a. be rendered in connection with an Injury or Illness;

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

c. 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:

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

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

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

d. 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

e. 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;

f. 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

g. 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:

a. 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;

b. a Covered Person's medical records;

c. protocol pursuant to which the treatment is to be delivered; or

d. any regulations and publications set forth by any governmental agency.

Medicare
Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Mental and Nervous Care/Substance Abuse
Such term includes treatment for mental and nervous disorders or conditions, as accepted by the general psychiatric community, including treatment for substance abuse.

Mental Illness
Serious mental illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

a. schizophrenia;

b. paranoid and other psychotic disorders;

c. bipolar disorders (hypomanic, manic, depressive, and mixed);

d. major depressive disorders (single episode or recurrent);

e. schizo-affective disorders (bipolar or depressive);

f. pervasive developmental disorders;

g. obsessive-compulsive disorders; and

h. depression in childhood and adolescence.

Morbid Obesity
A BMI greater than or equal to 40kg/m^2 without associated medical complications, or with BMI between 35 kg/m^2 and 39 kg/m^2 with significant associated medical complications.

Nurse Anesthetist
A Certified Registered Nurse Anesthetist (CRNA), who is a trained nurse who has specialized in anesthesia and possesses documented capability for giving anesthetics.

Obesity
A BMI greater than or equal to 35 kg/m^2 without significant associated medical complications.

Occupational Injury or Sickness
Any Injury, Sickness or dental condition that the Covered Person has or had a right to compensation under any workers' compensation law, occupational disease law, or other law of similar purpose or that resulted from employment or occupation for compensation.

Oral Surgery
Medically Necessary procedures for Surgery in the oral cavity, including pre- and post-operative care.

Orthodontic Treatment
The movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Outpatient
Services rendered on other than an Inpatient basis.

Physician
A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

"Physician" also includes the following providers, but only when the provider is licensed to practice where the care is rendered and is rendering a service within the scope of that license:

a. Dentist (D.D.S. or D.M.D.);

b. Optometrist (O.D.);

c. Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.);

d. Psychologist (Ph.D.); and

e. Chiropractor (D.C.).

"Physician" will also include the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, and is rendering a service to an individual who was referred to him by an M.D. or D.O.:

a. Physical therapist (P.T. or R.P.T.);

b. Speech pathologist;

c. Audiologist;

d. Certified Registered Nurse Anesthetist (C.R.N.A.);

e. Medical Social Worker (M.S.W.);

f. Licensed Professional Counselor (L.P.C.);

g. Physician’s Assistant (P.A.);

h. Certified Nurse Practitioner;

i. Certified Midwife; and

j. Occupational therapist (O.T.R.).

For purposes of certifying Total Disability, "Physician" will include only Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.).

Plan
The County of Rockwall Comprehensive Health Care Program as more fully described in this Plan Document.

Plan Administrator
See "Administrative Information" Section.

Plan Document
This Plan Document and Summary Plan Description, which shall serve as both the Plan Document and the Summary Plan Description which is required by ERISA.

Plan Sponsor
See "Administrative Information" Section.

Plan Year
A period of time commencing at 12:01 a.m. on the effective date, or any anniversary of the effective date, of this Plan and continuing until the next succeeding anniversary.

Pre-existing Condition
See Definitions and Explanation of Terms under Schedule of Benefits.

Preferred Provider Organization (PPO)
An organization that has contracted with the Plan Sponsor or the Contract Administrator to provide certain services to Covered Persons at specific rates. See the schedule of medical benefits for the special benefit level that applies to services obtained from contracted providers.

Pregnancy
Carrying a child, childbirth, miscarriage and complications arising there from.

Private Duty Nursing
Extended nursing services (up to 8 hours daily) available to participants who require more individual and continuous care than is available under the home health benefit. These services provided are by a registered nurse (RN) or license practical nurse (LPN), under the direction of the participant's physician, and in the participants home.

Prosthesis
An artificial device to replace a missing part of the body or to aid the function of a bodily organ.

Protected Health Information (PHI)
Any information that identifies an individual, or reasonably could be used to identify an individual.

Retiree
A former full-time active employee who was covered under the Plan upon retirement. and meets the following eligibility requirements:

a. Meets one of the criteria of the TEXAS COUNTY AND DISTRICT RETIREMENT SYSTEM (TCDRS) requirements for retirement as adopted by the County.

b. Retires under TCDRS on the same date of termination of full-time active employment. It must be the last date of the month.

c. A former full-time active employee who was covered under the Plan as a retiree as of January 1, 2009.

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

Sickness
Physician-diagnosed bodily Illness or disease, or congenital abnormalities of a covered newborn child. Mental health conditions are not included.

Significant Break in Coverage
A period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include a Waiting Period or an Affiliation Period.

Skilled Nursing Facility
An institution that:

a. is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

b. is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons and has facilities for the full-time care of at least five patients;

c. is under the full-time supervision of a Physician or a licensed registered graduate nurse (R.N.);

d. admits patients only upon the recommendation of a Physician;

e. maintains complete medical records;

f. has the services of a Physician available at all times; and

g. is not, other than incidentally, a nursing home, a hotel, a school, or a similar institution, a place of rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Specialty Drugs
Specialty Drugs are self-injectable, infused, and sometimes oral medications used to treat complex, chronic conditions such as Multiple Sclerosis, Hepatitis C, Transplants, Rheumatoid Arthritis, etc. and are classified as specialty pharmacy due to their special handling needs, patient administration education requirements, limited distribution channels and expense.

Spouse
A person of the opposite sex who is a husband or wife.

Surgery
Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Temporomandibular Joint Dysfunction
Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

Terminated Employee
Former active employee who is no longer employed by the County, regardless of reason for termination.

Total Disability or Totally Disabled
With reference to an Employee, disability resulting solely from a Sickness or Accidental Injury that prevents the Employee from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training, or experience.

For a Dependent, disability that prevents the Dependent from engaging in substantially all the normal activities of a person in good health of like age and gender.

A Covered Person must also be under the care of a Physician (M.D. or D.O.) in order to be considered Totally Disabled for benefit purposes.

Waiting Period
The period that must pass before an Employee or Dependent can become effective under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment is not a Waiting Period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a Waiting Period.

GENERAL PLAN INFORMATION

Funding - Sources and Uses

Employee Obligations
The health care coverage afforded to an Employee by this Plan shall be at least partially funded by the Plan Sponsor. If an Employee elects to enroll Dependents under the Plan, the Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer shall deduct such costs on a regular basis from the Employee's wages or salary.

Plan Sponsor Obligations
The Plan Sponsor shall also make contributions to the Plan for health care coverage. These contributions and those paid by Employee, if any, shall be placed in a special account or accounts administered by the Contract Administrator.

Use of Contributions
The contributions will be applied to provide the benefits under the Plan. Contributions may be used to purchase insurance coverage to ensure that the Plan will meet its self-funded health care coverage obligations. The policy may be reviewed upon request submitted to the Contract Administrator. The Contract Administrator is also available to answer any questions about the coverage. The provisions of this Plan Document in no way modify those of any insurance policy. Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Employer and the Contract Administrator.

Amount of Contributions
The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Plan Sponsor and by Employees (if any).

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

Administrative Provisions

Administration
The benefits of the Plan are administered by one or more Contract Administrators under the terms and conditions of administration agreements between the Employer and Contract Administrator.

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 the Covered Person.

The Plan will provide such alternative benefits at the Plan Administrator’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 Administrator’s right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Plan Administrator
The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to

make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

a. To administer the Plan in accordance with its terms;

b. To determine all questions of eligibility, status and coverage under the Plan;

c. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

d. To make factual findings;

e. To decide disputes which may arise relative to a Covered Person's rights;

f. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

g. To keep and maintain the Plan documents and all other records pertaining to the Plan;

h. To appoint and supervise a third party administrator to pay claims;

i. To perform all necessary reportings;

j. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;

k. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

l. To perform each and every function necessary for or related to the Plan’s administration.

Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or any trust agreement.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Annual Statements
If required by law, the Plan Sponsor shall furnish to each Employee, within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

Anticipation, Alienation, Sale, or Transfer
No benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to so anticipate, alienate, sell,

transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of or claims against any Covered Person, including claims of creditors, claims for alimony or support, or any like or unlike claims.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Entire Contract
The Plan Document, any amendments, and the individual applications, if any, of Covered Persons shall 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. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any employee or person any legal or equitable rights against the Plan Sponsor, the Plan Administrator, or their respective shareholders, directors or officers.

Facility of Payment
Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator determines that an 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 Administrator with an address at which he can be located for payment, the Plan Administrator may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee to the husband, wife, or relative by blood of the Employee or to any other person or institution determined by the Plan Administrator to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan Administrator may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brother, or sister, or to the Employee's estate, as the Plan Administrator in its sole discretion may designate. Any payment in accordance with this provision shall 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 shall be made to such guardian, conservator, or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, 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 shall use reasonable efforts to perform their respective obligations under the Plan.

Fraud
The following actions by any Covered Person, or a Covered Person’s knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which the Covered Person is a member:

a. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;

b. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;

c. Providing false or misleading information in connection with enrollment in the Plan; or

d. Providing any false or misleading information to the Plan.

Free Choice of Physician
Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO provider.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

Illegality of Particular Provision
The illegality of any particular provision of this Plan Document shall not affect the other provisions, but this Plan Document shall be construed in all respects as if such invalid provision were omitted.

Legal Actions
Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to the Injury or Sickness are Incurred or are alleged to have been Incurred. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claim Procedures for Health Care Coverage."

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Physical Examination and Autopsy
The Plan Administrator, at its own expense, shall 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 and to make an autopsy in case of death, where it is not forbidden by law.

Reimbursements
Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor shall 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 shall be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery
Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of this Plan Document, the Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Covered Person shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or his Dependents.

The Plan Administrator 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 such care or services have been provided, the Plan shall 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 hereunder. The Covered Person or his parent or guardian shall execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its rights under this provision.

Titles or Headings
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 its provisions.

Type of Plan
This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for Eligible Employees and Eligible Retirees of the Employer, their Eligible Dependents, and Qualified Beneficiaries under COBRA.

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.

ANNUAL NOTICES

Initial Notice of Your HIPAA Special Enrollment Rights

Loss of Other Coverage - If you are declining enrollment for yourself and/or your dependents (including your spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing towards your or your dependent's coverage. **[You will be required to submit a signed statement that this other coverage was the reason for waiving enrollment originally.]** To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after your other coverage ends or after the employer stops contributing towards the other coverage.

New Dependent as a Result of Marriage, Birth, Adoption or Placement for Adoption - If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependent(s). To be eligible for this special enrollment opportunity you must request enrollment **within 30 days** after the marriage, birth, adoption or placement for adoption.

Medicaid Coverage - The County of Rockwall Group Health Plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

1. TERMINATION OF MEDICAID OR CHIP COVERAGE- If the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility.

2. ELIGIBILITY FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHIP- If the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than provide direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan **within 60 days** after the date the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP or the date you or your dependent's Medicaid or state-sponsored CHIP coverage ends.

To request special enrollment or obtain more information, please contact Human Resources (972) 204-6188 or (972) 204-6187.

Maternity Coverage
For maternity stays, in accordance with federal law, the plan does not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean delivery. However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a cesarean delivery).

Women's Health and Cancer Rights
On October 21, 1998, Congress passed a bill called the *Women's Health and Cancer Rights Act*. This law requires group health plans that provide coverage for mastectomy to provide coverage for certain reconstructive services. These services include:

- Reconstruction of the breast upon which the mastectomy has been performed,
- Surgery/reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Physical complications during all stages of mastectomy, including lymphedemas

In addition, the plan may not:

- interfere with a woman's rights under the plan to avoid these requirements, or
- offer inducements to the health provider, or assess penalties against the health provider, in an attempt to interfere with the requirements of the law.

However, the plan may apply deductibles and copays consistent with other coverage provided by the plan.

If you have questions about the current plan coverage, please contact Human Resources (972) 204-6188 or (972) 204-6187.

HIPAA PRIVACY RULE AND SECURITY STANDARDS

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Director of Human Resources to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (*e.g.,* entering into business associate contracts; accepting certification from the Plan sponsor).

The Plan's disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the "504" provisions;

2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and

3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

Permitted disclosure of members' Protected Health Information to the Plan sponsor

The Plan (and any health insurance issuer or HMO servicing the Plan) will disclose members' Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's members by a health insurance issuer or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will not use or further disclose members' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

The Plan sponsor will not use or disclose members' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.
The Plan sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan sponsor becomes aware.

Notify *participants* of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);

Notify the Federal Trade Commission of any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318)

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the *Plan* or solicit bids from prospective issuers. *"Plan administration"* functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

Disclosure of members' Protected Health Information – Disclosure by the Plan sponsor

The Plan sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. § 164.524.

The Plan sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of members' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan sponsor will obtain authorization prior to the sale of any Protected Health Information;

The Plan sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Disclosure of *PHI* to Obtain Stop-loss or Excess Loss Coverage
The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator*, to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters *("MGUs")* for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards*.

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 members' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Human Resources Staff

2. Information Technology Personnel

3. County Treasurer's Staff

This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive members' 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 members' 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 members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

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.

Security Standards

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:

A. 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 received, maintains, or transmits on behalf of the Plan;

B. 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;

C. 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

D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as descried below:

1. 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
2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.
3. Notify *participants* of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318);
4. Notify the Federal Trade Commission of any *PHI* Security Incident of which the *Plan Sponsor*, or any *Business Associate* of the *Plan Sponsor* becomes aware, in accordance with the *health breach notification rule* (16 CFR Part 318).

Lifetime Limit
The lifetime limit on the dollar value of benefits under The County of Rockwall's group health plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information please contact the Human Resources Department (972) 204-6188 or (972) 204-6187.

Dependents to Age 26
Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in The County of Rockwall's group health plan. Individuals may request enrollment for such children within 30 days from the date of notice. Enrollment will be effective January 1, 2011. For more information please contact the Human Resources Department (972) 204-6188 or (972) 204-6187.

Designation of a Primary Care Provider
The County of Rockwall group health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Aetna Network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the 800-936-6340.

For children, you may designate a pediatrician as the primary care provider.

Access to Obstetrical or Gynecological Care
You do not need prior authorization from The County of Rockwall group health plan, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna or visit their website at www.aetna.com.

Flexible Spending Account (FSA)
The Health Care Spending Reimbursement account (FSA) will no longer allow for reimbursement of over the counter drugs without a prescription beginning January 1, 2011. Visit www.irs.gov for a list of approved expenses.

Preventive Care
Preventive Care coverage will no longer have an annual maximum for services using an Aetna contracted network provider. Preventive Care coverage is subject to national recommended guidelines based on age and gender.

MEDICARE PRESCRIPTION DRUG PART D—NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The County of Rockwall and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The County of Rockwall has determined that the prescription drug coverage offered by the The County of Rockwall's Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Creditable Coverage. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) because you lost creditable coverage to join Medicare drug plan.

In addition, if you lose or decide to leave employer sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

If you decide to join a Medicare drug plan, The County of Rockwall's Group Health Plan **coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.**

If you decide to join a Medicare drug plan and drop The County of Rockwall's Group Health Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

For more information about this notice or your current prescription drug coverage…

Contact the Human Resource Office at (972) 204-6188 or (972) 204-6187**.** **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The County of Rockwall Group Health Plan changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

Date:	October 15 and December 7th of each subsequent plan year
Name of Entity/Sender:	The County of Rockwall
Contact:	(972) 204-6188 or (972) 204-6187

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

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

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

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

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

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

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

GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583

MASSACHUSETTS – Medicaid and CHIP Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	CHIP Website: http://www.hsd.state.nm.us/mad/index.html CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647

PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

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