

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

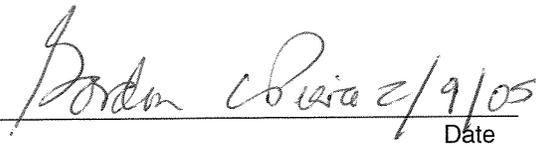
CITY OF TERRELL

**CITY OF TERRELL
EMPLOYEE HEALTH PLAN**

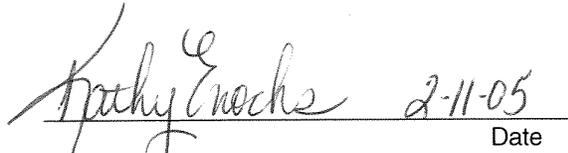
It is the intention of the Plan Sponsor, **City of Terrell**, to hereby amend and restate the Employee Health Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan".

IN WITNESS WHEREOF, the Plan Sponsor has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

Original effective date of the Plan: **October 1, 2003**; Amended and restated effective: **October 1, 2004**


Date

For Plan Sponsor:
Gordon C. Pierce, City Manager
City of Terrell


Date

For Claims Administrator:
Kathy Enochs, Chief Operating Officer
Group & Pension Administrators, Inc.

TABLE OF CONTENTS

	<u>PAGE</u>
GENERAL INFORMATION	3
INTRODUCTION	4-7
SCHEDULE OF BENEFITS	8-13
PRESCRIPTION DRUG PLAN	14-16
UTILIZATION REVIEW (UR) PROGRAM	17
CASE MANAGEMENT	18
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT	18
VOLUNTARY SECOND SURGICAL OPINION	18
PRE-EXISTING CONDITION EXCLUSION LIMITATION	19
PORTABILITY AND CREDITABLE COVERAGE	20
COMPREHENSIVE MEDICAL BENEFITS	21-23
MAJOR MEDICAL EXPENSE BENEFITS	24-29
MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS	30-33
TRANSPLANT POLICY	34
COORDINATION OF BENEFITS	35
COORDINATION PROCEDURES	36
COORDINATION WITH TRANSPLANT POLICY	37
COORDINATION WITH MEDICARE	37
COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE	37-38
SUBROGATION	39-40
CLAIM FILING PROCEDURES	41-44
GENERAL PROVISIONS	45-47
ELIGIBILITY FOR COVERAGE	48-49
QUALIFIED MEDICAL CHILD SUPPORT ORDERS/PLACEMENT FOR ADOPTION	50
EFFECTIVE DATE OF COVERAGE	51
EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS	51-52
ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE HEALTH PLAN	53
LATE ENROLLEE	53
COVERAGE CHANGES	54
TERMINATION OF COVERAGE	55
COVERAGE DURING LEAVE OF ABSENCE	56
REINSTATEMENT OF COVERAGE	57
FAMILY AND MEDICAL LEAVE	58
CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)	59-62
DEFINITIONS	63-78

GENERAL INFORMATION

This Plan Document describes the benefits for the Employees of **City of Terrell**.

Name of the Plan

City of Terrell Employee Health Plan

Plan Sponsor

City of Terrell
201 East Nash
Terrell, TX 75160
972-551-6600

Plan Administrator

City of Terrell
201 East Nash
Terrell, TX 75160
972-551-6600

Type of Plan

Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process

Legal Process may also be served on the Plan Administrator

Mary Gayle Ramsey, City Attorney
City of Terrell
201 East Nash
Terrell, TX 75160
972-551-6600

Claims Administrator

Group & Pension Administrators, Inc.
1500 N. Greenville Avenue, 4th Floor
Richardson, Texas 75081
972-238-7900

The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Plan Year

The twelve (12) month period beginning October 1 and ending September 30 of the next Calendar Year

Employer Tax ID Number

75-6000688

IRS Plan ID Number

501

INTRODUCTION

City of Terrell, hereinafter referred to as "Employer," hereby amends and restates the Employee Health Plan, a self-funded Employee Welfare Benefit Plan hereinafter referred to as the "Plan" pursuant to which Plan benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

GENERAL AUTHORITY OF THE PLAN ADMINISTRATOR

Subject to the claims administration duties delegated to the Claim Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including, without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Plan will be interpreted by the Plan Administrator in accordance with the terms of the Plan and their intended meanings. However, the Plan Administrator shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion it deems to be appropriate in its sole judgment. The validity of any such finding of fact, interpretation, construction or decision shall be upheld in any legal action and shall be binding and conclusive on all interested parties unless clearly arbitrary and capricious.

To the extent the Plan Administrator has been granted discretionary authority under the Plan, the prior exercise of such authority by the Plan Administrator shall not obligate it to exercise its authority in a like fashion thereafter.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

ADMINISTRATION OF THE PLAN

The Plan Administrator has full charge of the operation and management of the Plan. The Plan Administrator has retained the services of the Claims Administrator, an independent claims processor experienced in claims review.

The Plan Administrator is the named fiduciary of the Plan except as noted herein. The Plan Administrator maintains discretionary authority to interpret the terms of the Plan, including but not limited to, determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect and shall be binding on all persons, unless it can be shown that the interpretation or determination was arbitrary and capricious.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare providers are not agents or delegates of the Plan Sponsor, Employer, Plan Administrator, Employer or Benefit Services Manager. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher Out-of-Pocket expenses if the Covered Person uses the services of a Non-preferred Provider.

PREFERRED PROVIDER INFORMATION

This Plan contains provisions under which a Plan Participant may receive more benefits by using certain providers. These providers are individuals and entities that have contracted with the Plan to provide services to Plan Participants at pre-negotiated rates. A list of these Preferred Providers will be periodically provided automatically and free of charge by the Plan Administrator. In addition, a Plan Participant may request a Preferred Provider list by contacting the Plan Administrator. The Preferred Provider list changes frequently; therefore, it is recommended that a Plan Participant verify with the provider that the provider is still a Preferred Provider before receiving services.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Medical Expenses.

EFFECTIVE DATE

Original effective date of the Plan: **October 1, 2003**; Amended and restated effective: **October 1, 2004**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information Section.

NAMED FIDUCIARY

The named Fiduciary is **City of Terrell**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Employer may delegate responsibilities for the operation and administration of the Plan. The Employer shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service providers, adjust their compensation (if any), and exercise general administrative authority over them. The Employer has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

In the event that the Employer terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

The Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose claim for benefits has been denied, for a fair review of the decision denying the claim by the person designated by the Plan Administrator for that purpose. Details of the claims procedure are found in this Plan Document under the section entitled "Claim Filing Procedures."

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

PLAN AMENDMENTS

This Document contains all the terms of the Plan and may be amended by the Plan Sponsor from time to time by a written resolution of the Employer. Any such Plan Amendment shall become effective as of the date specified in the enabling resolution. A copy of any Plan Amendment shall be furnished to the Plan Administrator and any outside provider of plan administrative services.

MATERIAL MODIFICATIONS

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the modification or change. Covered Employee and beneficiaries must be furnished a Summary of such modifications or changes, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a summary of Material Modifications or changes does not apply to any Employee covered by the Plan who

would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reductions disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

TERMINATION OF PLAN

The Plan Sponsor reserves the right at any time to terminate the Plan or any benefit under the Plan by a written resolution of the Employer to that effect. Previous contributions by the Employer and Employees shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

SCHEDULE OF BENEFITS

Major Medical Benefits for Covered Persons

Benefit Levels for services rendered in the geographical zip code area serviced by the Preferred Provider Organization (PPO):

The "PPO Benefit" applies to services rendered by Preferred Providers in the designated PPO Network (In-Network); the "Non-PPO Benefit" applies to services rendered by providers other than Preferred Providers (Out-of-Network). In addition, the "PPO Benefit" also applies to the following situations:

1. If a PPO Provider refers a Covered Person to a facility which is not in the PPO Network because no appropriate PPO facility is available;
2. If a Covered Person has no choice of PPO Providers in the specialty that the Covered Person is seeking within the PPO service area;
3. If a Medical Emergency or initial treatment of an Accidental Injury requires immediate care and services are rendered by Non-PPO Providers; or
4. If a Covered Person seeks treatment in a PPO Hospital or Free-standing Facility and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon or emergency room Physician.

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Lifetime Major Medical Maximum Benefit Per Covered Person	\$1,000,000	\$1,000,000
Calendar Year Deductible Per Covered Person	\$0	\$750
Family Limit*	N/A	\$1,500
Benefit Percentage (Unless otherwise noted)	80%	60%
Annual Out-of-Pocket Maximum (In addition to Deductible and Copays) Per Covered Person	\$3,500	\$6,000
Family Limit*	\$7,000	\$12,000
Inpatient Hospital Services (All related charges) UR Notification required	80%	60% after Deductible
Room and Board Limit	Semi-Private	Average Semi-Private
Intensive Care Limit	Negotiated PPO Fee Usual and Customary	Usual and Customary
Additional Deductible Penalty Per Admission (Failure to notify Utilization Review (UR) Company of Hospital admission, see Utilization Review Program section)	\$500	\$500
Hospital Emergency Room Copay waived if admitted Inpatient	100% after \$50 Copay	60% after \$50 Copay Deductible applies
Emergency Room Physician	80%	60% after Deductible

NOTE: The Annual Out-of-Pocket Maximum is determined by combining both PPO and Non-PPO Covered Charges. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year. The Lifetime and Calendar Year Maximum Benefits are also determined by combining PPO and Non-PPO Covered Charges.

*Applies collectively to all Covered Persons in the same Family.

SCHEDULE OF BENEFITS (Cont'd.)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Urgent Care Facility (Minor Emergency Medical Clinic) See Office Visit below	100% after \$20 Copay	100% after \$20 Copay
Ambulance Service	80%	80% Deductible waived
Outpatient Surgery/Ambulatory Surgical Center	80%	60% after Deductible
Lab and X-ray Benefit (Procedures performed in the Physician's office, Outpatient department of Hospital, free-standing center or independent facility)		
Select Diagnostic Medical Procedures (MRI, CT scan, etc., see list in Comprehensive Medical Benefits section)	80%	60% after Deductible
All Other Lab/X-ray	100% Copay waived	100%; Copay and Deductible waived
Physician Office Services		
Office Visit (Includes examination, treatment, tests and supplies provided by and billed by Physician at the time of the office visit, except Surgery, chemotherapy/radiation therapy, infusion therapy, Physical Therapy, Occupa- tional Therapy, Speech Therapy, allergy testing, allergy serum/injections and Select Diagnostic Medical Procedures)	100% after \$20 Copay	100% after \$20 Copay Deductible waived
Office Surgery	80%	60% after Deductible
Sterilization Procedures	80%	60% after Deductible
Contraceptive Devices, Implants and Injectables	80%	60% after Deductible
Allergy Testing/Serum and Injections	80%	60% after Deductible
Other In-Office Services (without Office Visit billed)	100% after \$20 Copay	100% after \$20 Copay Deductible waived
Voluntary Second Surgical Opinion	100% after \$20 Copay	100% after \$20 Copay Deductible waived
All Other Physician Services	80%	60% after Deductible

SCHEDULE OF BENEFITS (Cont'd.)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Maternity (Including prenatal, delivery and postnatal care) Office Visit Copay does not apply Lab and X-ray Benefit applies	80%	60% after Deductible
Birth Center	80%	60% after Deductible
Routine Newborn Care Inpatient Hospital nursery charges and pediatric care to date of baby's discharge. Payable under covered mother's claim.	80%	60% Deductible waived
Chemotherapy/Radiation Therapy/ Dialysis/Infusion Therapy Notify the Utilization Review Company for coordination of care.	80%	60% after Deductible
Wig during Chemotherapy/Radiation Therapy	80%	60% after Deductible
Lifetime Maximum Benefit	1	1
Cardiac Rehabilitation	80%	60% after Deductible
Physical Therapy/Occupational Therapy/ Speech Therapy	80%	60% after Deductible
Durable Medical Equipment (DME)/ Medical Supplies	80%	60% after Deductible
Diabetic Self-Management Training	80%	60% after Deductible
Temporomandibular Joint Syndrome (TMJ) Office Visit	100% after \$20 Copay	100% after \$20 Copay Deductible waived
All Other Covered Services	80%	60% after Deductible
Chiropractic Services Office Visit Copay does not apply	80%	60% after Deductible
Calendar Year Maximum Benefit (Includes x-rays)	\$1,000	\$1,000

SCHEDULE OF BENEFITS (Cont'd.)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Rehabilitation Facility UR Notification required*	80%	60% after Deductible
Skilled Nursing Facility UR Notification required*	80%	60% after Deductible
Maximum Number of Covered Days Per Calendar Year	120	120
* Notification to the Utilization Review (UR) Company is required within forty-eight (48) hours following admission.		
Home Health Care Notify the Utilization Review Company for coordination of care.	80%	60% after Deductible
Home Infusion Therapy Notify the Utilization Review Company for coordination of care.	80%	60% after Deductible
Hospice Notify the Utilization Review Company for coordination of care.	80%	60% after Deductible
Lifetime Maximum Benefit	6 months	6 months
Private Duty Nursing Notify the Utilization Review Company for coordination of care.	80%	60% after Deductible
Organ and Tissue Transplants, Donor Expenses Notify Utilization Review Company upon transplant evaluation for coordination of care. (Refer to Employer's Transplant Policy – Primary payor) See Major Medical Expense Benefits, #49		

SCHEDULE OF BENEFITS (Cont'd.)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Mental and Nervous Disorders and Serious Mental Illness		
See Plan Definitions		
Inpatient/Outpatient Psychiatric Day Treatment Facility UR Notification required	80%	60% after Deductible
Inpatient/Outpatient Psychiatric Day Treatment Facility/Residential Treatment Center Combined Maximum Number of Covered Days per Calendar Year (Maximum does not apply to Serious Mental Illness)	30	30
Two (2) days Day Treatment equal one (1) day Inpatient		
Two (2) days Residential Treatment Center equal one (1) day Inpatient		
Psychological Testing	80%	60% after Deductible
Office Visit (Includes Outpatient Group Therapy)	100% after \$20 Copay	100% after \$20 Copay
Maximum Number of Covered Office Visits Per Calendar Year (Maximum does not apply to Serious Mental Illness)	30	30
Outpatient Mental and Nervous Benefits do not apply to Annual Out-of-Pocket Maximum.		
Chemical Dependency, Drug and Substance Abuse		
Lifetime Maximum Benefit	3 series of treatments	3 series of treatments
Inpatient/Outpatient Day Treatment Facility/Residential Treatment Center UR Notification required	80%	60% after Deductible
Office Visit Office Visit Copay does not apply	80%	60% after Deductible
Outpatient Chemical Dependency, Drug and Substance Abuse Benefits do not apply to Annual Out-of-Pocket Maximum.		

SCHEDULE OF BENEFITS (Cont'd.)

	<u>PPO Benefit</u>	<u>Non-PPO Benefit</u>
Preventive and Wellness Care Benefits		
This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam.		
Covered Wellness Procedures:		
1. Annual Routine Physical Exam (Including lab, x-ray and routine diagnostic testing and other medical screenings)	100% after \$20 Copay	100% after \$20 Copay
2. Annual Well Woman Exam (Including pap smear and other routine lab)	100% after \$20 Copay	100% after \$20 Copay
3. Annual Mammography (routine)	100% Copay waived	100%; Copay and Deductible waived
4. Bone Density test (routine)	100% Copay waived	100%; Copay and Deductible waived
5. Annual PSA test (routine)	100% Copay waived	100%; Copay and Deductible waived
6. Well-Baby Care/Well-Child Care Exam (other than Routine Newborn Care)	100% after \$20 Copay	100% after \$20 Copay
7. Routine Immunizations	100% Copay waived	100%; Copay and Deductible waived
8. Flu shots/pneumonia shots	100% Copay waived	100%; Copay and Deductible waived
9. Routine Colonoscopy	80%	60% after Deductible
All Other Covered Medical Expenses, not listed in the Schedule of Benefits (subject to Plan Maximums and Limitations), are payable at applicable Benefit Percentage after satisfying the Calendar Year Deductible.	80%	60% after Deductible*

* Non-PPO Benefit level will apply when a Covered Person is living or traveling outside the geographical zip code area serviced by the PPO (Out-of-Area) unless charges are incurred as a result of a Medical Emergency or Accidental Injury.

PRESCRIPTION DRUG PLAN

Prescription Card Service

Supply Limit

Generic Drugs (Tier 1)

Preferred Brand Name Drugs (Tier 2)

Non-Preferred Brand Name Drugs (Tier 3)

100% after applicable Copay

30 days

\$10 Copay

\$20 Copay

\$30 Copay

Mail Order Service

Supply Limit

Generic Drugs (Tier 1)

Preferred Brand Name Drugs (Tier 2)

Non-Preferred Brand Name Drugs (Tier 3)

100% after applicable Copay

90 days

\$20 Copay

\$40 Copay

\$60 Copay

If the Pharmacy charge is less than the Generic or Brand Copay, then the actual charge will become the Copay. Generic and Brand Name Copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible or Annual Out-of-Pocket Maximum. To be covered, prescription drugs must be:

1. Purchased from a participating licensed pharmacist; and
2. Dispensed to the Covered Person for whom they are prescribed.

DEFINITIONS

Brand Name Drugs

Trademark drugs or substances marketed by the original manufacturer.

Generic Drugs

Drugs or substances which:

1. Are not trademark drugs or substances;
2. May be legally substituted for trademark drugs or substances; and
3. Are legally prescribed by a Qualified Prescriber.

Prescription Drugs

Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury, or Pregnancy.

Qualified Prescriber

A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/ her practice, prescribe drugs or medicines.

Product Selection

The pharmacist substitutes more economically priced generic equivalent drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when state law requires no substitution for the Brand Name Drug.

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Drug Review

The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Prescription Drug Plan – Drugs Covered

1. Legend drugs (drugs requiring a prescription either by federal or state law). See Exclusion list below for exceptions.
2. Insulin on prescription.
3. Disposable insulin needles/syringes, test strips and lancets on prescription.
4. Compounded medication of which at least one ingredient is a prescription legend drug.
5. Legend oral contraceptives.
6. Seasonale (Mail Order Service only).
7. Contraceptive patches.
8. Contraceptive rings.
9. Injectable contraceptive.
10. Prenatal vitamins.
11. ADD (Attention Deficit Disorder)/ADHD (Attention Deficit Hyperactivity Disorder) drugs.
12. Gleevec.

Prescription Drug Plan – Exclusions

1. Prescription vitamins except prenatal.
2. OxyContin.**
3. Stadol.
4. Injectable form of legend drugs.*
5. Contraceptive devices (unless listed as covered).
6. Fertility drugs.
7. Drugs prescribed for impotence/sexual dysfunction.
8. Levonorgestrel (Norplant).
9. Abortifacients/RU-486.
10. Anorectics (any drug used for the purpose of weight loss).
11. Growth hormones.
12. Immunization agents, biological sera, blood or blood plasma.
13. Drugs for the treatment of alopecia (baldness).
14. Non-legend drugs other than those listed above.
15. Smoking deterrent medications or any other smoking cessation aids, all dosage forms.
16. Tretinoin, all dosage forms (e.g. Retin-A).
17. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above.
18. Charges for the administration or injection of any drug.
19. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws.
20. Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
21. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceutical.
22. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.

*** These Prescription Drugs may be covered under Major Medical Expense Benefits if determined to be Medically Necessary. Submit the drug receipt along with a letter of Medical Necessity from the prescribing Physician. If the Prescription Drug is determined to be Medically Necessary and covered under the Plan, benefits will be payable at the PPO Benefit Percentage of the Plan. Prescription Drugs covered under Major Medical Expense Benefits are subject to the Pre-existing Condition Exclusion Limitation of the Plan.**

**** Covered with prior authorization if Medically Necessary.**

NOTE: Prescription Drugs covered under the retail and Mail Order Prescription Drug Plan are not subject to the Pre-existing Condition Exclusion Limitation of the Plan.

A Prescription Drug dispensed by a pharmacy or Mail Order Service for which a Copay applies is not considered a Claim for benefits under this Plan and therefore is not subject to the Plan's Claim Filing Procedures.

The Plan reserves the right, in its sole discretion, to authorize alternative care and treatment.

PRESCRIPTION DRUG UTILIZATION REVIEW

Prescription Drug use does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic claim audits which may help to protect patients from potential drug interactions or drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves claim review and may include communication by the Prescription Drug Plan and/or the Utilization Review Company with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her providers.

UTILIZATION REVIEW (UR) PROGRAM

The Utilization Review program is designed to help all Plan Participants receive Medically Necessary and appropriate health care. Review for Medical Necessity, Concurrent Review and Retrospective Review are provided by the Utilization Review Company. Services provided will be reviewed to ensure treatment meets the Utilization Review Company's criteria for Medical Necessity. **Notification must be provided to the Utilization Review Company of all Inpatient Hospital/Facility admissions and confinements as detailed below.**

HOSPITAL/FACILITY ADMISSION NOTIFICATION

Notification of all Hospital/Facility admissions (including admissions for treatment of Mental and Nervous Disorders or Substance Abuse) and admissions to rehabilitation facilities is required. **Notification to the Utilization Review Company must be made within forty-eight (48) hours following any Hospital/Facility admission (or the next business day if holiday or weekend admission).**

The Utilization Review Company nurse may discuss with the Physician and/or Hospital/Facility the diagnosis, the need for hospitalization versus alternative treatment, and length of any Hospital/Facility confinement. The Utilization Review Company will notify the Physician and/or Hospital/Facility verbally or electronically of the outcome of the Utilization Review Company's review.

Failure to notify the Utilization Review Company or comply with these requirements will result in an additional \$500 Deductible applied to all Covered Hospital/Facility Expenses for that confinement.

NOTE: Please refer to the Plan Participant identification card for name and phone number of Utilization Review Company. Notification of a Hospital/Facility admission is required under the Plan and constitutes a Claim for benefits; however, any such action taken by the Utilization Review Company does not constitute a Benefit Determination. All claims are subject to all Plan requirements, such as Medical Necessity, Pre-existing Condition Exclusion Limitations, Major Medical Expense Benefits, Plan Exclusions and Limitations and Eligibility provisions at the time care and services are provided.

CONCURRENT REVIEW

Following notification of a Hospital/Facility admission, a concurrent review of treatment will be conducted by the Utilization Review Company. "Concurrent Review" means the Utilization Review Company will monitor the Covered Person's Hospital stay and periodically evaluate the need for continued hospitalization. In addition, the Utilization Review Company may assist with discharge planning and address the health care needs of the patient upon release. This may involve consultation with the Covered Person's Physician and comparison of clinical information to nationally accepted criteria.

If a Hospital/Facility confinement continues beyond the number of days approved as part of the Concurrent Review, no benefits will be payable for room and board for any unauthorized days of confinement.

If a penalty is imposed for failure to use the Utilization Review Company, that amount will never be included as part of the Calendar Year Deductible or Annual Out-of-Pocket Maximum.

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and the Utilization Review Company may initiate Case Management. Case Management is provided by nurses with specialized training and/or advanced national certification. The nurse may monitor the medical care, consult with the Physicians, coordinate with the health care providers and facilities, and communicate with the patient and family to promote receipt of appropriate, cost effective care to expedite the recovery process. Referrals to Centers of Excellence and Out-of-Network fee negotiations may be included in the Case Management process.

When Out-of-Network fees are negotiated by Case Management and/or the Utilization Review Company on behalf of the Plan, Out-of-Network Covered Charges will be payable at the PPO Benefit level.

ALTERNATIVE CARE

Through alternative care and treatment suggestions, Case Management can help the patient and the Plan Administrator control the costs related to a serious Injury or Illness.

When alternative care and treatment are recommended by Case Management and approved by this Plan, the Plan may pay for all or part of the charge for a service or supply not shown as a Covered Expense in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. This Plan reserves the right at its sole discretion to authorize alternative care and treatment. In exercising its authority, this Plan will act in a way as not to discriminate against any Plan Participant. In addition, charges not covered by the Plan or Covered Charges exceeding the Plan's internal Maximum Amounts, but recommended by Case Management and approved by the Plan, may be considered Covered Medical Expenses.

All benefits provided under this section are subject to Medical Necessity and Usual and Customary charges.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Plan will not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, the Plan will pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier. The Plan will not require that a provider obtain authorization from the Plan prescribing a length of stay less than forty-eight (48) hours or ninety-six (96) hours, as applicable.

This provision is subject to the requirements of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

VOLUNTARY SECOND SURGICAL OPINION

When a Physician recommends surgery for a Covered Person, it is not required that the Covered Person obtain a Second Surgical Opinion. It is voluntary and no penalty will apply if a Second Surgical Opinion is not obtained.

The Plan will provide 100% coverage, less the Office Visit Copay, for the cost of a second or third surgical consultation.

PRE-EXISTING CONDITION EXCLUSION LIMITATION

A Pre-existing Condition is any physical or mental illness or injury (regardless of the cause) for which medical advice, diagnosis, care or treatment was recommended or received, for which drugs were prescribed, for which a Physician was consulted or for which medical expenses were incurred during the **six (6) month period** immediately prior to the Covered Person's Enrollment Date in the Plan. Medical advice, diagnosis, care or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

Coverage for that condition will be provided on:

1. The date on which the Covered Person completes a **twelve (12) month** exclusion period beginning with the Covered Person's Enrollment Date in the Plan; or
2. In the case of a Late Enrollee, the date on which the Late Enrollee completes an **eighteen (18) month** exclusion period beginning with the Late Enrollee's Enrollment Date in the Plan.

ENROLLMENT DATE FOR DETERMINING PRE-EXISTING CONDITION EXCLUSION PERIOD

The Enrollment Date determines when the six (6) month Pre-existing Condition look-back period begins and when the twelve (12) month / eighteen (18) month Pre-existing Condition exclusion period begins and ends.

The Enrollment Date for an eligible Employee who enrolls in the Plan during his/her initial eligibility period is the first day of the Employee's Waiting Period in the Plan (Employee's Date of Hire). The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan.

See Effective Date of Coverage sections of this Plan for Special Enrollment qualifications, enrollment limitations and requirements for Late Enrollees.

EXCEPTIONS

The Pre-existing Condition exclusion limitation will not apply to those Covered Persons covered on the restated date of this Plan, who were also covered by the terms of the Plan and who would not be subject to an exclusion or reduction of benefits because of such prior plan's Pre-existing Condition limitation.

The Pre-existing Condition exclusion limitation will not apply to Prescription Drugs covered under the Prescription Drug Plan.

The Pre-existing Condition exclusion limitation is waived for a newborn child of a Covered Employee or newly adopted child of a Covered Employee if adopted or placed for adoption with the Employee while the Employee is covered under this Plan. The newborn and/or adopted child must be enrolled in the Plan within thirty-one (31) days after the date of birth, adoption or Placement for Adoption for the exception to apply.

Pregnancy and Genetic Information will not be considered a Pre-existing Condition even if medical advice, diagnosis, care or treatment was recommended or received prior to the Covered Person's Enrollment Date in the Plan.

The Pre-existing Condition exclusion limitation may be reduced or eliminated by periods of Creditable Coverage. See Portability and Creditable Coverage section.

The Pre-existing Condition exclusion limitation is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

PORTABILITY AND CREDITABLE COVERAGE

The Plan shall reduce the Pre-existing Condition exclusion period for a Covered Person by any periods of Creditable Coverage that an individual proves he/she had without a Significant Break in Coverage. A Certificate of Coverage from prior plan(s), must be provided to the Plan Administrator at the time of enrollment in this Plan.

SIGNIFICANT BREAK IN COVERAGE

A Significant Break in Coverage is a period of sixty-three (63) consecutive days or more during which the Employee or Dependent did not have any Creditable Coverage. Waiting Periods are not considered in determining Significant Breaks in Coverage.

WAITING PERIOD

A Waiting Period is the time between the first day of employment and the first day of coverage under the Plan. Any period of time before a Special Enrollment or Late Enrollment is not considered a Waiting Period.

The Waiting Period is counted when determining the Pre-existing Condition exclusion period, but days in a Waiting Period do not count for Creditable Coverage or for a Significant Break in Coverage.

See Effective Date of Coverage sections of this Plan for requirements on Special Enrollment and Late Enrollment.

CERTIFICATE OF COVERAGE

To verify Creditable Coverage, a Certificate of Coverage (COC) will be issued without charge to an individual who terminates coverage with a group health plan or individual plan.

The Plan will assist an Employee in obtaining a Certificate of Coverage from a prior plan if requested. If, upon review of the Certificate of Coverage, a Pre-existing Condition Exclusion will still be imposed on an individual, the person will be notified in writing of this decision.

AUTOMATIC CERTIFICATE OF COVERAGE

A Certificate of Coverage should be provided automatically by group health plans and health insurance issuers under these circumstances:

1. If termination of coverage is a result of a COBRA Qualifying Event and the individual is a qualified beneficiary, a Certificate of Coverage must be provided within the same period of time as the notice of COBRA rights;
2. If an individual has elected COBRA continuation coverage or the Plan has provided continued coverage after the COBRA Qualifying Event, the Plan must provide another Certificate of Coverage automatically within a reasonable period of time after COBRA continuation coverage ceases; and
3. If the termination of coverage is not a COBRA Qualifying Event, the Certificate of Coverage must be provided within a reasonable time period.

CERTIFICATE OF COVERAGE UPON REQUEST

Plans and issuers will furnish a Certificate of Coverage within a reasonable period of time if the request is made by or on behalf of an individual within twenty-four (24) months after health coverage ceases. A Certificate of Coverage will also be issued upon request even if health coverage remains in force.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean the Usual and Customary (U&C) charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

COVERED CHARGES

If a Covered Person incurs Covered Medical Expenses as the result of an Illness or Injury, the Plan will pay benefits as shown in the Schedule of Benefits.

DEDUCTIBLE AMOUNT

The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Non-PPO Covered Medical Expenses incurred during the remainder of that year. It is the amount shown in the Schedule of Benefits as the Calendar Year Deductible. There is no Deductible carry-over from one Calendar Year to the next for Covered Charges incurred and applied to the Deductible in the last three (3) months of a Calendar Year.

DEDUCTIBLE FAMILY LIMIT

The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) in the same Calendar Year, no further Deductibles will be applied to Non-PPO Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year.

COINSURANCE

The portion of Covered Medical Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20% and/or 60%/40%) after any applicable Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

ANNUAL OUT-OF-POCKET MAXIMUM

The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year, excluding:

- The Calendar Year Deductible;
- Copays (Office Visit, Urgent Care Facility, Hospital Emergency Room);
- Prescription Copays;
- Covered Charges for the Outpatient treatment of Mental and Nervous Disorders;
- Covered Charges for Outpatient treatment of Chemical Dependency, Drug and Substance Abuse;
- Any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits;
- Charges in excess of Usual and Customary (U&C);
- Any non-compliance penalty applied when a Covered Person fails to notify the Utilization Review Company of a Hospital admission; and
- Room and board charges for Hospital confinement in excess of the days approved as part of the Concurrent Review.

Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year.

HOSPITAL EMERGENCY ROOM COPAY (PER VISIT)

The portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges each time the Covered Person is treated in a Hospital Emergency Room. After the Copay, the Calendar Year Deductible applies to Non-PPO benefits before benefits are payable. The Copay is waived if admitted Inpatient. The Emergency Room Copay cannot be used to satisfy the Calendar Year Deductible or Annual Out-of-Pocket Maximum. Emergency Room Physician charges are subject to any applicable Deductible and Coinsurance.

PPO OFFICE VISIT COPAY (PER VISIT)

The portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Physician office visit and each Physician visit at an Urgent Care Facility. Whenever an Office Visit Copay applies, the Calendar Year Deductible is waived for that visit except for procedures listed in the Schedule of Benefits which are not subject to the Office Visit Copay. The Office Visit Copay cannot be used to satisfy the Calendar Year Deductible or Annual Out-of-Pocket Maximum.

SELECT DIAGNOSTIC MEDICAL PROCEDURES (CUSTOM)

The following is a list of Select Diagnostic Medical Procedures that may be performed in a Physician's office, the Outpatient department of a Hospital, free-standing center or an independent facility. Benefits are available under the Plan as specified in the Schedule of Benefits:

1. Bone scan – Specialized x-ray of bone tissues using radioactive injection if more sensitive to bone irregularities than usual x-rays:
 - a. Limited area
 - b. Multiple areas
 - c. Whole body
 - d. With vascular flow, only
 - e. Three phase technique
 - f. Tomographic (SPECT)
2. Cardiac stress test:
 - a. Thallium – Use of radioactive dye to define areas of decreased blood flow in vessels of the heart while the patient exercises.
 - b. Treadmill – Reading of the electrical patterns of the heart (EKG) while the patient exercises on a treadmill.
3. CT Scan – Computerized x-ray picture of a part of the body.
4. MRI (Magnetic Resonance Imaging) – Diagnostic imaging modality that uses magnetic and radio frequency fields to image body tissue non-invasively.
5. PET Scan (Positron Emission Tomography) – A three dimensional imaging technique that allows visual examination of the internal organs and illustrates organ function.
6. Myelogram – X-ray of the spine after injection of a contrast medium (dye) into a space in the spinal canal.
7. Aorthography, Angiography, Lymphangiography, Venography, Transcatheter, Transluminal Atherectomy and Diskography.

NETWORK SERVICES (PPO)

Network Services (PPO) are health care services provided by a Physician, Hospital or other provider in the designated PPO with whom the Plan has contracted to provide services at specified fees. Network Covered Charges will be payable at the PPO Benefit level.

OUT-OF-NETWORK SERVICES (NON-PPO)

Out-of-Network Services (Non-PPO) are health care services provided by a Physician, Hospital or other provider who is not in the Plan's designated PPO network. Out-of-Network Covered Charges will be payable at the Non-PPO benefit level unless the Plan has a direct contract for discounting fees with the Out-of-Network Provider in which case, the PPO Benefit level will apply.

CALENDAR YEAR MAXIMUM BENEFIT

The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person's effective date through December 31 of the same year. The Calendar Year Maximum Benefits are determined by combining PPO and Non-PPO Covered Charges.

LIFETIME MAXIMUM BENEFIT

The Maximum Amount payable for all Covered Expenses incurred during each Covered Person's lifetime is as specified in the Schedule of Benefits. The word "Lifetime" as used herein, means the duration of participation in this Plan and prior Plan Years maintained by the Employer, either as an Employee, Dependent or COBRA Qualified Beneficiary. The Lifetime Maximum Benefits are determined by combining PPO and Non-PPO Covered Charges.

MAJOR MEDICAL EXPENSE BENEFITS

The following are Covered Expenses under this Plan, unless specifically excluded under the Major Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to Usual and Customary (U&C), which is the usual amount accepted as payment for the same service within a geographical area, and/or the negotiated fee schedule of the Preferred Provider Organization (PPO).

1. The **Hospital** charges for:
 - a. The actual **room and board** expenses incurred for a **ward or Semi-Private room** up to the limits as shown in the Schedule of Benefits, or 90% of the most common Private room rate for a Hospital that does not have Semi-Private accommodations.
 - 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. **Miscellaneous Hospital services** and supplies during Hospital confinement.
 - d. Inpatient Charges for **nursery room and board**.
 - e. Outpatient Hospital services and supplies and **Emergency Room** treatment.
2. The charges incurred for confinement in a **Rehabilitation Facility**.
3. The charges incurred for confinement in a **Skilled Nursing Facility/Extended Care Facility** subject to the Maximum and the Benefit Percentage specified in the Schedule of Benefits; however, such expenses are limited as follows:
 - a. The attending Physician certifies that confinement is Medically Necessary. Only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was confined will be eligible.
 - b. Semi-Private daily room and board limit.
4. The charges by a **Home Health Care** Agency for care for a Homebound patient in accordance with a Home Health Care Plan subject to the Benefit Percentage specified in the Schedule of Benefits.

Home Health Care Plan Covered Benefits:

- a. Part-time or intermittent nursing care visits by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a Licensed Vocational Nurse (L.V.N.), or Public Health Nurse who is under the direct supervision of a Registered Nurse;
- b. Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;
- c. Physical, occupational, speech and respiratory therapy services by licensed therapists;
- d. Services of a Certified Social Worker (C.S.W. - A.C.P.); and
- e. Medical supplies, drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the patient had remained in the Hospital.

Home Health Care Plan Exclusions:

- a. Services and supplies not included in the Home Health Care Plan;
 - b. Services of a person who is a Close Relative of the Covered Person;
 - c. Services of any social worker unless designated C.S.W. - A.C.P.;
 - d. Transportation services;
 - e. Food or home delivered meals; and
 - f. Custodial Care and housekeeping.
5. The charges for **Private Duty Nursing Care** provided by a licensed nurse (R.N., L.P.N. or L.V.N.) are covered to this extent:
 - a. **Inpatient Nursing Care**. Charges are covered only when care is Medically Necessary or not Custodial Care and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - b. **Outpatient Nursing Care**. Charges are covered only when care is Medically Necessary and not Custodial Care. The only charges covered for Outpatient Care are those listed for Home Health Care.

6. The charges for **Home Infusion Therapy** by a licensed provider to include intravenous infusion or injection of fluids, nutrition or medication done in the home setting.
7. The charges relating to **Hospice care** provided that the Covered Person has a life expectancy of six (6) months or less. Covered Hospice expenses are limited to:
 - a. Room and board for confinement in a Hospice.
 - b. Ancillary charges furnished by the Hospice while the Covered Person is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
 - c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
 - d. Physician services and/or nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Vocational Nurse (L.V.N.).
 - e. Home health aide services.
 - f. Home care charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including custodial care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse, or a home health aide.
 - g. Medical social services by licensed or trained social workers, psychologists or counselors.
 - h. Nutrition services provided by a licensed Dietitian.
8. The charges incurred for a Medically Necessary **Surgical Procedure**.
9. When two or more **Surgical Procedures** occur during the same operation, the Covered Expenses for all charges are as follows:
 - a. When multiple or bilateral Surgical Procedures that increase the time and amount of patient care are performed, the Covered Expense is the allowable fee for the major procedure plus 50% of the allowable fee for each of the lesser ones or the actual fee charged, whichever is less. This provision will not apply to those procedures which are not subject to the Multiple Procedures Reduction Rules per Medicare.
 - b. When an incidental procedure is performed through the same incision, the Covered Expense is the fee for the major Surgical Procedure only. Examples of incidental procedures are: excision of a scar, appendectomy, lysis of adhesions, etc.
10. When services of an **assistant surgeon** and/or licensed surgical assistant are required to render technical assistance at an operation, the Covered Expense for such services shall be limited to 25% of the allowable surgical fee. See definition of Practitioner for covered providers.
11. The charges for the following **Dental expenses** and **Oral Surgical Procedures**:
 - a. Excision of wholly or partly un-erupted impacted teeth;
 - b. Cutting procedures in the oral cavity for tumors or cysts of the jawbone;
 - c. Open or closed reduction of a fracture or dislocation of the jaw; and
 - d. Treatment necessitated by Accidental Injury to sound natural teeth.
12. The charges for **Cosmetic Surgery** only in the following situations:
 - a. Reconstructive Surgery as a result of an accidental bodily Injury;
 - b. The surgical correction required as a result of a congenital disease or anomaly;
 - c. Reconstructive Surgery following neoplastic (cancer) surgery;
 - d. Reconstruction of the breast on which a mastectomy has been performed;
 - e. Surgery and reconstruction of the other breast to produce symmetrical appearance;
 - f. Coverage for prostheses and physical complications related to all stages of covered mastectomy including lymphedemas, in a manner determined in consultation with the attending Physician and patient; and
 - g. Removal of breast implants if deemed to be Medically Necessary and reconstructive breast surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removal of the implants is covered, if Medically Necessary, even if the original implant was for cosmetic reasons.

NOTE: The Plan's breast reconstruction surgery benefits are subject to the requirements of the Mastectomy Provision of the Women's Health and Cancer Rights Act of 1998.

13. The charges for the services of a legally qualified **Physician** for medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations.
14. The charges for **cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:
 - a. Under the supervision of a Physician;
 - b. In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
 - c. Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
 - d. In a facility whose primary purpose is to provide medical care for an Illness or Injury.
15. The charges for **Physical Therapy** for the treatment or services rendered by a licensed Physical Therapist under direct supervision of a Physician at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.
16. The charges for **Occupational Therapy** for treatment rendered by a licensed Occupational Therapist under supervision of a Physician at a facility whose primary purpose is to provide medical care for an Injury or Illness.
17. The charges of an **Audiologist** under direct supervision of a Physician to restore hearing loss or correct an impaired hearing function.
18. The charges of a legally qualified **Speech Language Pathologist** under direct supervision of a Physician for restorative **Speech Therapy** for speech loss or speech impairment due to an Illness, Injury or Congenital Anomaly or due to surgery performed because of an Illness or Injury, other than a functional nervous disorder (i.e., stuttering, repetitive speech).
19. The charges for services of a licensed **Dietitian** when recommended by a licensed M.D. or D.O. except for services which are otherwise excluded by the Plan.
20. The charges for professional licensed **Ambulance** service as follows:
 - a. Ground transportation when Medically Necessary and used locally to or from the nearest Hospital qualified to render treatment;
 - b. Air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest facility qualified to render treatment (excluding commercial flights); or
 - c. "CARE" and "LIFE" flights in a life-threatening situation.
21. The charges for **drugs** requiring the written prescription of a licensed Physician; such drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Drugs excluded from the Prescription Drug Plan which are determined to be Medically Necessary and Covered Charges are payable under Major Medical Expense Benefits.
22. The charges for **insulin, insulin syringes, test strips and lancets** on prescription are covered by the Prescription Drug Card or Mail Order Service.
23. The charges for **glucometers** and insulin pumps/supplies when ordered by a Physician.
24. The charges for **clinical and pathological laboratory tests** and examinations including fees for professional interpretation of their results.
25. The charges for radiation services including **diagnostic x-rays** and interpretation, x-ray therapy and treatment.
26. The charges for **Radiation Therapy, Chemotherapy, Infusion Therapy and Dialysis**.
27. The charges for one (1) **wig** per Lifetime per Covered Person during Chemotherapy or Radiation Therapy.

28. The charges for the processing and administration of **blood** or blood components, but not for the cost of the actual blood or blood components if facility receives any replacement of blood used for which the patient is not financially responsible.
29. The charges for **Chiropractic Services**, excluding maintenance therapy, subject to the Calendar Year Maximum Benefit specified in the Schedule of Benefits to include x-rays.
30. The charges for **oxygen** and other gases and their administration.
31. The charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established **diagnostic tests** generally approved by Physicians throughout the United States.
32. The charges for the cost and administration of an **anesthesia and/or anesthetic**.
33. The charges for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), corrective shoes and other necessary **medical supplies**.
34. The charges for **nerve stimulators** and TENS units.
35. The charges for rental of a wheelchair, Hospital bed and other **Durable Medical Equipment** prescribed by a Physician and required for temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the lifetime expectancy of the equipment.
36. The charges for **Jobst elastic stockings** when ordered by a Physician limited to three (3) pairs per Calendar Year.
37. The charges for **custom bras for prostheses** following a mastectomy limited to six (6) per Calendar Year.
38. The charges for artificial limbs and eyes to replace natural limbs and eyes and other necessary **prosthetic devices**, but not the replacement thereof, unless the replacement is necessary because of physiological changes.
39. The charges for testing for the initial diagnosis of **infertility**. This is limited to procedures for diagnostic purposes only.
40. The charges for **Genetic testing** when there is a history of a genetic disorder in the Family.
41. The charges for formulas necessary for the treatment of **phenylketonuria** or other heritable diseases. The benefits will be paid on the same basis that benefits would be paid for drugs ordered by a Physician. Phenylketonuria means an inherited condition that may cause severe mental retardation if not treated.
42. The charges for **Maternity care**, on the same basis as any Illness covered under this Plan, for Covered Employees and covered Dependent spouses only. Other Dependents are not eligible for benefits under this provision. Plan coverage for a Hospital stay in connection with childbirth for both the mother and the newborn child will be no less than: forty-eight (48) hours following a normal vaginal delivery; or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.
43. The charges for **Routine Newborn Care** for a well newborn child for Nursery room and board and routine Inpatient services required for the healthy newborn following birth. Covered Expenses will also include charges for pediatric services, newborn hearing exams and circumcision. Benefits will be payable from the date of birth until the date the child is discharged. Covered Charges are not subject to a separate Calendar Year Deductible and are payable under covered mother's claim.
44. The charges for **injectable contraceptive serum** administered in a Physician's office.
45. The charges for insertion and removal of **contraceptive implants** and **IUD's** as a surgical procedure in a Physician's office and the cost and fitting of **diaphragms**.

46. The charges for services for voluntary **Sterilization** for Covered Employees and covered Dependent spouses.
47. The charges made by an **Ambulatory Surgical Center, Minor Emergency Medical Clinic and Birthing Center**.
48. The charges for the services of a Licensed State-Certified **Midwife** who is a Registered Nurse (R.N.).
49. The charges related to or in connection with human **Organ and Tissue Transplants** and organ donor expenses will be considered first by the Employer's fully-insured Transplant Policy as the Primary payor. If charges related to human organ and tissue transplants and organ donor expenses incurred by a Covered Person on this Plan are not covered by the Employer's fully-insured Transplant Policy, the charges would be considered by this Plan. See Coordination with Transplant Policy section. Covered Charges will be payable on the same basis as any Illness based on the Benefit Percentage specified in the Schedule of Benefits. All charges are subject to the Pre-Existing Condition Limitations and Eligibility provisions of this Plan at the time care and services are provided. For additional information, see Transplant Policy section.
50. The charges for treatment of **Mental and Nervous Disorders and Serious Mental Illness** will be payable as specified in the Schedule of Benefits. Benefits for Mental and Nervous Disorders are subject to the provisions of the Mental Health Parity Act of 1996 and any related amendments.
51. The charges for treatment in a **Residential Treatment Center for Children and Adolescents** and through a Crisis Stabilization Unit for Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse, subject to the Lifetime/Calendar Year Maximum Benefit as shown in the Schedule of Benefits. Benefits are payable subject to the following:
 - a. The treatment must be received for a serious mental Illness which impairs the patient's thought, perception of reality, emotional process or judgment or grossly impairs behavior as manifested by recent disturbed behavior which would otherwise require Hospital confinement if treatment were not available through a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents;
 - b. The treatment is based on an Individual Treatment Plan;
 - c. The provider is licensed or operated by the appropriate state agency or board to provide the treatment. A Crisis Stabilization Unit must be licensed or certified by the applicable state Department of Mental Health and Mental Retardation; and
 - d. For determination of benefits, each two (2) days of treatment will be equal to one (1) day of treatment in a Hospital.
52. The charges for treatment of **Chemical Dependency, Drug and Substance Abuse**. Inpatient/Outpatient Chemical Dependency Treatment Facility expenses shall also be payable as shown in the Schedule of Benefits.
53. The charges for **psychological testing** and **Outpatient group therapy**. Outpatient Group Therapy is subject to the Maximum Number of Covered Office Visits specified in the Schedule of Benefits under Mental and Nervous Disorders.
54. The charges for treatment of **Temporomandibular Joint Syndrome (TMJ)** and related care to include the initial diagnostic visit, x-rays of the joint, injections into the joint and surgical repair of the temporomandibular joint, to exclude dental and orthodontic services.
55. The charge for hyperalimentation or **Total Parenteral Nutrition (TPN)** for persons recovering from or preparing for surgery.
56. The charges for **Covered Wellness Procedures** listed as Preventive and Wellness Care Benefits.
57. The charges for complications incurred as a result of **immunizations**.
58. The charges for Hospital "**admit kits**."
59. The applicable **sales tax** for covered services and supplies.

60. The charges for the diagnosis and treatment of **Attention Deficit Disorder (ADD)** with the exclusion of charges for education and training.
61. The charges for **Allergy testing and treatment** as specified in the Schedule of Benefits.
62. The charges for **diabetic self-management medical and nutritional training** for diagnosed cases of diabetes rendered by a licensed Practitioner when recommended as a course of treatment by a Physician.

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons:

1. Charges incurred **prior to the effective date** of coverage under the Plan, or after coverage is terminated.
2. Charges incurred as **a result of war or any act of war**, whether declared or undeclared, or caused during service in the armed forces of any country.
3. Charges resulting from or sustained as a result of participation in a **riot or civil insurrection**.
4. Charges arising out of or in the course of any **occupation for wage or profit**, whether or not the Covered Person is entitled to benefits under any **Workers' Compensation** or Occupational Disease Law, or any such similar law.
5. Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any state, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.
6. Charges incurred for which the Covered Person, in the absence of this coverage, is **not legally obligated to pay**, or for which a charge would not ordinarily be made in the absence of this coverage.
7. Charges for Injury sustained while the Covered Person was **operating an automobile or other motor vehicle (including a motorcycle) under the influence of alcohol**, in an amount over the legal limit, or any illegal substance, whether or not the Covered Person was convicted or received any type of fine, penalty, imprisonment or other sentence or punishment.
8. Charges for Injury resulting from or sustained **during the commission, or attempted commission, of an assault or a crime punishable as a felony**, whether or not the Covered Person was convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or an act of domestic violence.
9. Charges incurred in connection with any **self-inflicted Injury or Illness** unless the Injury or Illness is a result of a medical condition (either physical or mental) or an act of domestic violence.
10. Charges for research studies and **Experimental** medical procedures, treatment, drugs, devices and related services considered to be Experimental/Investigational in nature as defined in the Plan Definitions. The Claims Administrator retains the right to have such medical expenses reviewed by an independent panel of peer reviewers to determine whether such expenses are considered accepted, standard medical treatment or are Experimental/Investigational.
11. Charges for any services or supplies **not considered legal in the United States**.
12. Charges incurred as the result of **travel outside the United States** or its territories **specifically to receive medical treatment**.
13. Charges incurred for services or supplies which constitute **personal comfort or beautification items**, television or telephone use, or charges in connection with Custodial Care or expenses actually incurred by other persons.
14. Charges incurred in connection with the care or treatment of, or operations which are performed for **Cosmetic** purposes of any kind including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment, *except* for Cosmetic Surgery procedures listed as covered in Major Medical Expense Benefits, see item #12.

15. Charges for **wigs** and hairpieces unless charges are incurred for hair loss during Chemotherapy or Radiation Therapy.
16. Charges in **excess of Usual and Customary charges** or charges not recommended and approved by a Physician.
17. Charges incurred in connection with services and supplies which are **not Medically Necessary** for treatment of an active Illness or Injury unless listed as Covered Wellness Procedures in the Preventive and Wellness section of the Schedule of Benefits.
18. Charges for **Custodial Care** and maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.
19. Charges for treatment, services and supplies provided by a **Close Relative** of the Covered Person, as defined in this Plan.
20. Charges for Hospitalization primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test **not connected with an active Illness or Injury**.
21. Hospital charges for **room and board for any day not authorized** by the Utilization Review Company as part of the Concurrent Review.
22. Charges for **Physician's fees** for any treatment which is not rendered by or provided under the supervision of a Physician.
23. Charges incurred in connection with **routine vision exams** or eye refractions and the purchase or fitting of **eyeglasses and contact lenses**. This exclusion/limitation shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.
24. Charges for any surgical procedure for the correction of a visual refractive problem including **radial keratotomy, lasik or similar surgical procedures**.
25. Charges incurred in connection with **routine hearing exams** and charges for the purchase or fitting of **hearing aids** or such similar aid devices. This exclusion does not apply to Routine Newborn hearing exams and the initial purchase of a hearing aid if the loss of hearing is a result of an Illness, Accidental Injury or surgical procedure.
26. Charges incurred for treatment on or to the **teeth**, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for covered **Oral Surgical procedures** and treatment required because of Accidental Injury to sound natural teeth. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture or bridgework. Injury to teeth from chewing or biting is not considered an Accidental Injury.
27. Charges for callus or corn paring or excision; toenail trimming; any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain, orthopedic shoes (unless attached to a brace), orthotics or other devices for support of the **feet**, except for:
 - a. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
 - b. Removal of nail roots; and
 - c. Foot treatment required because of a metabolic or peripheral vascular disease.
28. Charges for the treatment of **obesity**, morbid obesity and charges related to weight control including Surgery (i.e., gastric by-pass and similar surgical procedures) and complications incurred as a result of such Surgery for obesity.

29. Charges for **weight loss programs** and **nutritional supplements** even when recommended by a Physician.
30. Charges for the treatment of **smoking/tobacco addiction** even when overall health of patient would be improved.
31. Charges for **Botox injections** unless Medically Necessary for the following diagnoses: achalasia, hemifacial spasm (once brain tumor is ruled out), neurogenic incontinence secondary to spinal cord Injury when other treatments have failed, blepharospasm, spasmodic torticollis or cervical dystonia, strabismus (patient specific).
32. Charges for **education or training** of any type including those for learning disabilities except diabetic self-management medical training for diagnosed cases of diabetes.
33. Charges for **acupuncture, hypnotherapy, behavior training, biofeedback** and similar programs.
34. Charges for the treatment of **Mental and Nervous Disorders** in excess of the Calendar Year Maximum Benefits as specified in the Schedule of Benefits.
35. Charges for the treatment of **Chemical Dependency, Drug and Substance Abuse in excess of the three (3) separate series of treatments per Lifetime.**
36. Charges for **marriage counseling** and **Family counseling.**
37. Charges for **I.Q. testing.**
38. Charges for the treatment of **Sleep Disorders**, apnea or nocturnal hypoxemia, including sleep studies/diagnostic testing, surgery, facility, equipment and devices.
39. Charges for **Chiropractic Services in excess of the Calendar Year Maximum Benefit** as specified in the Schedule of Benefits and maintenance therapy in accordance with the Utilization Review Company's criteria for maintenance care.
40. Charges for **massage therapy** unless services are provided under a Physical Therapy Treatment Plan.
41. Charges for services or supplies rendered to any Covered Employee or Dependent in connection with the **voluntary interruption of a Pregnancy**, unless the voluntary interruption of Pregnancy is Medically Necessary and the life of the Covered Person would be endangered if the fetus were carried to term, or if Pregnancy is the result of a criminal act such as rape or incest, or if a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion. Benefits for treatment of complications arising from, or as the result of, any voluntary interruption of Pregnancy will be payable on the same basis as an illness.
42. **Pregnancy and maternity charges** incurred by Dependents other than Covered Dependent Spouses including Complications of Pregnancy.
43. Charges related to or in connection with **newborns of Dependent children**, unless newborn child meets the definition of an eligible Dependent.
44. Charges for portable **uterine monitors** unless approved by the Utilization Review Company and/or Case Management.
45. Charges related to or in connection with the treatment of **infertility** to include fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination or in-vitro fertilization or other similar procedures.
46. Charges resulting from or in connection with the **reversal of a sterilization procedure.**
47. Charges for any form of **contraception** that does not require the written prescription of a Physician.

48. Charges related to or in connection with **sex change procedures** and charges for **sexual dysfunctions** or inadequacies that do not have a physiological or organic basis.
49. Charges related to or in connection with **Experimental Organ and Tissue Transplants** including any animal organ transplants.
50. All **transplant charges** covered under the Employer's fully-insured transplant policy. See Transplant Policy section.
51. Charges for dental and orthodontic care related to **Temporomandibular Joint Syndrome (TMJ)**, disorders of mastication, malocclusion of teeth, misalignment of mandible and maxilla and jaw pain to include services, supplies and splints.
52. Charges for **Speech Therapy** to correct pre-speech deficiencies or therapy to improve speech skills not fully developed unless related to an illness or injury.
53. Charges subject to the **Pre-existing Condition Exclusion Limitation** of the Plan except charges for Prescription Drugs covered under the Prescription Drug Plan are not subject to the Pre-existing Condition Exclusion Limitation. For complete list of Pre-existing exceptions, refer to the Pre-existing Condition Exclusion Limitation section.
54. Any portion of the billed charges for services or supplies which the **provider offers to waive**, such as the portion which would not be paid by the Plan due to Deductible or Coinsurance provisions.
55. Charges for purchase or rental of **Continuous Passive Motion (CPM) equipment**, unless used for post surgical rehabilitation.
56. Charges incurred for **procurement and storage of one's own blood** except for procurement and storage of one's own blood if obtained within three (3) months prior to a scheduled surgery.
57. Charges for **adoption or surrogate fees, completion of form fees, missed appointment fees or late fees**.
58. Charges for **telephone or online consultations with a Physician** and/or provider.
59. Charges for Claims received after **twelve (12) months** from the date the service was rendered.

TRANSPLANT POLICY

HUMAN ORGAN & TISSUE TRANSPLANT BENEFITS

This Health Plan Document includes a special attachment regarding human organ and tissue benefits, as explained in full in the **AIG LIFE** Organ & Tissue Transplant Policy. All Eligible Employees and their Dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate policy, according to its terms and conditions, from the time of their evaluation through three hundred sixty-five (365) days post transplant operation. After this specified benefit period has elapsed, all transplant-related medical benefits will revert to the terms and conditions of health coverage under this Health Plan.

Benefits available for Human Organ and Tissue Transplants are subject to the following:

- A. The Employee and Dependent(s) are eligible for medical benefits under the group's Health Plan;
- B. The Employee and Dependent(s) meet all the terms and conditions outlined in the **AIG LIFE** Organ and Tissue Policy/Certificate; and
- C. The Employee and Dependent(s) do not have a Pre-existing Condition as defined in the **AIG LIFE** Organ and Tissue Policy/Certificate.

Those Employees and their Dependents who are initially excluded from human organ and tissue transplant coverage under the **AIG LIFE** Organ and Tissue Transplant Policy (due to a Pre-existing Condition) will continue to receive health care benefits as they relate to transplantation according to the terms and conditions of the Employer Health Plan until eligible for benefits under the separate **AIG LIFE** policy.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Plan may pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan Maximums.

For organ and tissue transplants, see Coordination with Employer's fully insured Transplant Policy section. The reduced Benefits payable under this Plan for organ and tissue transplants which when added to the benefits payable by the Transplant Policy, will not exceed benefits payable under this Plan, if this Plan were primary.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

For purposes of this Coordination of Benefits provision the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
 - a. Hospital indemnity benefits; and
 - b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including no fault automobile insurance on an individual basis.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term "Allowable Expense" means any necessary item of expense, for which the charge is Usual and Customary, or is based on the contracted fee schedule of an alternate care delivery system, a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

The term "Claim Determination Period" means a Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom claim is made, has been covered under this Plan.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or employee or as a Dependent, under any other plan which has no provision similar in effect to this provision.
2. Dependents' benefits under this Plan who are also eligible for benefits:
 - a. As an insured person or employee under any other plan; or
 - b. As a Dependent child of an insured person or employee covered under any other plan.
3. A Covered Person under this Plan who is also eligible for benefits as an insured person or employee under any other plan and has been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this provision, or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision or to determine its applicability.

ORDER OF BENEFIT DETERMINATION

Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.
2. The plan which covers the Covered Person as an employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the claimant as a Dependent.
3. If the Covered Person is a Dependent child:
 - a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
 - b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
 - c. If the plan with which this Plan is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.
4. If the Covered Person is a Dependent child and the parents are divorced, then:
 - a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
 - b. The plan of a step-parent with whom the child lives pays second (if applicable).
5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed paid under this Plan and to the extent of such payments, the Plan Administrator will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable Maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

COORDINATION WITH TRANSPLANT POLICY

All Covered Persons who are eligible for the Employer's fully-insured Transplant Policy will be entitled to benefits under this Plan only after consideration of transplant expenses by the Employer's Transplant Policy. The Transplant Policy is always the Primary payor and pays before any benefits for this Plan are considered unless the insured person is eligible for Medicare or is a dependent covered by another employer's group plan. This Plan will always be the Secondary payor unless charges are not covered by the Transplant Policy. This Plan may pay either its benefits in full or a reduced amount which, when added to the benefits payable by the Transplant Policy, will not exceed the benefits payable under this Plan if this Plan were Primary. Only the amount paid by this Plan will be charged against the Plan Maximums. This Plan will fully coordinate its benefits, as Secondary payor, against the benefits provided under the above referenced transplant policy.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Covered Persons who are eligible for Medicare benefits, may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile accident is based on the type of automobile insurance law enacted by the Covered Person's state. Nationally, there are three types of state automobile insurance laws:

1. No-fault automobile insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

COORDINATION WITH AUTO NO-FAULT COVERAGE

Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy nor does it intend to be primary in order to reduce the premiums or cost of no-fault automobile coverage.

If the Covered Person or their Covered Dependent incur Covered Charges as a result of an automobile accident (either as driver, passenger or pedestrian), the amount of Covered Charges that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Charge; and
4. Any expense that the Plan is required to pay by law.

Any individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident.

If Covered Person's state has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile accident for the Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person's state does not have a no-fault automobile insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile accident and as a result of the accident, the Plan pays benefits and if the Covered Person receives a settlement from their uninsured or underinsured motorist policy, the Plan is entitled to receive from the proceeds of the settlement with the uninsured or underinsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

SUBROGATION

PLAN'S RIGHT TO SUBROGATION AND REIMBURSEMENT

In the event of any benefit payments made under the Plan to or on behalf of a Covered Person an automatic equitable subrogation lien, to the extent of such payments, attaches in favor of the Plan to all the rights of recovery and other rights of the Covered Person arising out of any claim or cause of action that may accrue because of the alleged malpractice, accidental, negligent, intentional, or tortious conduct, act or omission, of another person or entity (hereinafter all such persons or entities will be individually and collectively referred to as a "third party"). The Covered Person, by participation in this Plan, agrees that he/she and his/her estate, and the legal representatives of his/her estate, will be obligated and that the Plan will be fully subrogated under this automatic equitable subrogation lien to any recovery or right of recovery that he/she or the estate may have against any third party, including without limitation, any wrongful death claim. State law doctrines and rules, such as the "make whole" doctrine, the "anti-assignment" rule, or any other state law or rule, will not prevent the Plan from recovering 100% of its payments from the proceeds of the recovery.

The Covered Person, or the legal representative of beneficiaries of the Covered Person or his/her estate, must notify the Plan Administrator of any claim or lawsuit against a third party or insurance carrier within thirty (30) days of the date that the claim is made or the lawsuit is filed. The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its automatic equitable subrogation lien against a third party or insurance carrier.

THE COVERED PERSON'S AGREEMENT TO SUBROGATION AND REIMBURSEMENT

The Covered Person, on behalf of himself/herself and each beneficiary of a payment made on the Covered Person's behalf, by accepting any benefits under the Plan, consents and agrees:

1. That the Plan will be promptly reimbursed for 100% of the payments made to or on the Covered Person's behalf under the Plan out of the first monies recovered as a result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement (regardless of whether there has been a full recovery or such sums are allocated to any particular type of loss, damage or expense and regardless of whether the Covered Person has been fully compensated for his losses or "made whole"); and
2. To include all benefits paid or payable under the Plan in any liability or other claim against a third party or its insurance carrier. Furthermore, the Covered Person and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, subrogation and reimbursement agreements, and other instruments as the Plan Administrator or its agent may require to facilitate enforcement of the Plan's equitable subrogation lien and reimbursement rights, and not to prejudice, or in any way detrimentally affect, such rights. The Plan's rights will not be affected by any release, including a partial release, that is entered into without the consent of the Plan Administrator.

The Plan's automatic equitable subrogation lien and reimbursement rights will extend to:

1. All conceivable sources of recovery, other than the Plan itself, including, by way of example and not limitation, any and all automobile insurance coverage (including uninsured/underinsured motorist coverage), no-fault coverage, medical insurance coverage, school insurance coverage, disability coverage, personal injury awards or settlements, and medical malpractice awards or settlements; and
2. All types of payments made by or on behalf of a third party, regardless of how designated, including without limitation, payments for medical expenses, disability, accidental death or dismemberment, past or future wages or loss of earnings capacity, pain and suffering, mental anguish, loss of consortium or companionship, and exemplary damages of any kind. For purposes of clarity and not limitation, to the extent that a recovery from a third party is obtained by an attorney for the Covered Person, the full amount that the Plan is entitled to recover hereunder will not be offset or otherwise reduced by any attorney's fees or other costs of recovery that were not specifically approved in advance in writing by the Plan Administrator or its designated agent.

LIMITATION TO THE PLAN'S SUBROGATION AND REIMBURSEMENT RIGHTS

The Plan's automatic equitable subrogation lien and reimbursement rights:

1. Will extend only to the recovery by the Plan of all the benefits that it has paid or will pay to or on behalf of the Covered Person and the cost of prosecuting the claim for recovery, including reasonable attorney's fees and court and collection costs; and
2. Will fully apply and control even if the Covered Person or beneficiary thereof has only received a partial recovery from a third party.

SUBROGATION AND REIMBURSEMENT RIGHTS NOT AFFECTED BY PAYMENT

The Plan's automatic equitable subrogation lien and reimbursement rights will not be affected if benefits are paid under the Plan before the Plan Administrator or its agent obtains any additional agreements from the Covered Person (or from any other payee) or if the Plan Administrator does not request any such agreement. In addition, the failure or refusal of a Covered Person (or other payee, if applicable) to sign an agreement at the request of the Plan Administrator or its agent recognizing the Plan's automatic equitable subrogation lien and reimbursement rights may result in a forfeiture of all benefits payable to that Covered Person (or other payee), as determined by the Plan Administrator, even if such benefits have already been paid. The Plan Administrator will retain a right to fully recover paid benefits which are forfeited in such a manner; moreover, any such failure or refusal will not affect the Plan's rights which will remain in full force and effect.

LIEN ON PROCEEDS

The Plan Administrator, on behalf of the Plan, will have a first and primary equitable lien against the proceeds of any settlement, award or judgment that results from a claim, lawsuit or other action by or on behalf of a Covered Person who received benefits under the Plan. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Plan Administrator will be entitled to:

1. Deduct the amount of the lien from any future claims payable to or on behalf of the Covered Person if:
 - a. The lien is not repaid or otherwise recovered by the Plan Administrator; or
 - b. The Covered Person or other claimant fails to promptly notify the Plan Administrator of such a payment received from a third party or insurance carrier that is subject to the Plan's equitable subrogation lien and reimbursement rights.
2. To otherwise take any action that the Plan Administrator deems necessary or appropriate, in its discretion, to enforce the Plan's rights to automatic equitable subrogation lien and reimbursement rights to the full extent permitted by law.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this Plan or any other plan, the Plan Administrator or Claims Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator or Claims Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Plan. Any person claiming benefits under this Plan shall furnish to the Plan Administrator or Claims Administrator such information as may be necessary to implement this provision. This paragraph does not apply to obtaining and releasing Protected Health Information (PHI), which is addressed in a separate section of this Plan.

CLAIM FILING PROCEDURES

NOTICE AND PROOF OF CLAIM FOR BENEFITS

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. Claims must be filed within twelve (12) months from the date of service in order for such Claims to be considered for coverage by the Plan. If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage must be filed within twelve (12) months from the date of service or the Claims will not be covered by the Plan. Claims must be filed sooner in certain circumstances. If the Plan is terminated, all Claims incurred prior to the Plan termination must be received within ninety (90) days after the termination or the Claims will not be covered. Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

CLAIMS DETERMINATION

The Plan Administrator maintains procedures to evaluate health care Claims, to determine benefits and to review Claim appeals for disputed determinations. Time periods are established for responding to and reviewing all Claims made under the Plan. These time periods specify the maximum time allowed for each phase of the Claims process. All time is measured in calendar days beginning from the date the Claim is received, even if the Claim is incomplete when received. When additional information is requested by the Claims Administrator (other than as part of an Adverse Benefit Determination), the time period for making a Benefit Determination is tolled until the additional information is received by the Claims Administrator or until the claimant's allotted time for responding to the request for additional information expires, whichever happens first.

The Plan Participant will be notified of the Plan's Benefit Determination as follows:

Time Periods for Initial Benefit Determinations:

1. Initial Determination – After receiving the Claim, the Plan has thirty (30) days in which to make a Benefit Determination.
2. Extension of Initial Determination Period – One (1) extension of fifteen (15) days is permitted if the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan and notifies the Claimant of the extension before the expiration of the initial thirty (30) day period of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

Notice of Insufficient Information and Time Allowed Claimant to Provide Additional Information – If an extension, as described in (2), is necessary because additional information is needed from the Claimant in order for the Claims Administrator to process the Claim, the notice of the extension must specifically describe the required information, and the Claimant must be afforded forty-five (45) days from the receipt of the notice to provide the specified information.

Time Periods for Appeal of Adverse Benefit Determinations:

1. Time to Seek Appeal of Adverse Benefit Determination – A Claimant has one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination.
2. Time for Decision on Appeal – There are two (2) levels of appeal, each of which requires a determination to be made within thirty (30) days of the receipt of the request, as explained further in the section entitled "Appeals Process."

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;
2. References to the Plan provisions on which the Adverse Benefit Determination is based;
3. A description of any 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 review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination;
5. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and
6. If the Adverse Benefit Determination is based on a Medical Necessity or experimental 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 on request.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an Adverse Benefit Determination to file an appeal of that determination. The appeal process will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant or an Authorized Representative of the Claimant with the proper form for review of Adverse Benefit Determination initiates the appeal process.
2. The Claimant will have the opportunity to submit written comments, documents, records and other information relating to the Claim.
3. The Claimant will be provided, on 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. The review of the Adverse Benefit Determination will take 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 initial Benefit Determination.
5. No deference will be afforded to the initial Benefit Determination.
6. The party reviewing the appeal may be neither the party who made the initial Adverse Benefit Determination nor a subordinate of the party who made the initial Adverse Benefit Determination.
7. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Claims Administrator or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care

professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

8. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified.
9. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of the Plan Administrator and will be decided within thirty (30) days of the Plan Administrator's receipt of the request.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The Claimant will be notified of the Benefit Determination on Appeal. If there is an Adverse Benefit Determination on Appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;
2. References to the Plan provisions on which the Adverse Benefit Determination is based;
3. A description of any 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 review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination;
5. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;
6. If the Adverse Benefit Determination is based on a Medical Necessity or experimental 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 on request;
7. If the notification is a notification of an Adverse Benefit Determination on the final level of appeal, a statement of the Claimant's right to bring an action under section 502(a); and
8. 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."

Legal actions for benefits under the Plan may be brought by the Claimant following an Adverse Benefit Determination on appeal.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a utilization review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the reasonable, necessary and Usual and Customary guidelines as determined by the Plan.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care provider rendering such services. Such payment to a health care provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment and the Plan Administrator will not be required to see the application of the money so paid.

GENERAL PROVISIONS

RIGHTS OF RECOVERY

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

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

WAIVER OR ESTOPPEL

No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each 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 that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of, and does not affect any requirement for coverage by Workers' Compensation Insurance or where permitted and applicable any other alternative form of Workers' Compensation benefits.

CONFORMITY WITH LAW

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

CONFORMITY WITH STATUTE(S)

Any provision of the Plan, which is in conflict with statutes that are applicable to this Plan, is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES

All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date post-marked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

ASSIGNMENT

The benefits provided under this Plan shall not be assignable without the consent of the Plan Administrator. The Employee may authorize the Plan Administrator to pay benefits directly to the Hospital, Physician or other party providing medical treatment. Any such payment will discharge the Plan to the extent of payment made. Unless permitted by law, payments may not be attached, nor be subject to the Employee's debts.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

FACILITY OF PAYMENT

If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges claim is based; or
2. A surviving relative (spouse, parent or child).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

Effective April 14, 2004, the Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Standards of the Health Insurance and Portability Act of 1996 (the "HIPAA Privacy Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information", as described in the HIPAA Privacy Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)

Effective April 14, 2004, the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.
2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Standards), and including quality assurance, claims processing, auditing and monitoring of the Plan.
3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan documents or by law.
4. The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.
5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.
6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.
7. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.
8. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.
9. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.
10. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.
11. The Plan Sponsor must, if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.
12. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time in various Business Associate Agreements between the Plan and the Plan's Business Associates or in other documents governing the administration of the Plan.
13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan document by persons described in paragraph 12 above through training, sanctions and other disciplinary action, as necessary.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan Document as follows.

EMPLOYEE ELIGIBILITY

An Eligible Employee under the Plan shall include only Employees who meet both of the following conditions:

1. Is regularly scheduled to work for the Employer on a Full-time Employment basis for at least thirty (30) hours per week; and
2. Has satisfied a Waiting Period of thirty (30) days of continuous employment.

WAITING PERIOD

A Waiting Period is the period of time an Employee must satisfy while working for the Employer before becoming eligible for the Plan.

The Plan's Waiting Period for all Employees is thirty (30) days.

DATE OF ELIGIBILITY

Each Employee will be eligible for coverage the date he/she meets the Employee Eligibility requirements in 1 and 2 stated above.

RETIREE ELIGIBILITY

The City of Terrell provides group health coverage up to sixty-six (66) months plus eighteen (18) additional months as required under the COBRA rules and regulations at City cost for Retirees. Retirees who meet one or more of the following conditions are covered by this Plan:

1. Employees who retire under the Texas Municipal Retirement System plan with the City of Terrell, Texas as his/her last employer with twenty (20) years of service with the City of Terrell, Texas and be at least fifty-five (55) years of age; or
2. Employees who retire under the Texas Municipal Retirement System plan with creditable service from other entities shall have been employed by the City of Terrell, Texas for the last ten (10) years prior to retiring and having accumulated a total of twenty (20) years of service in the Texas Municipal Retirement System and be at least fifty-five (55) years of age; or
3. Employees who retire with twenty (20) years of creditable service under the Texas Municipal Retirement System plan.

For any Retiree who is eligible for and elects to accept health coverage under this Plan, the City of Terrell will pay the premium for such health coverage for any such Retiree for a maximum of seven (7) continuous years or until he/she becomes eligible for Medicare/Medicaid, whichever occurs first.

DEPENDENT ELIGIBILITY

A Dependent, as defined in the Plan Definitions, will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage or the date the Dependent is acquired, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. A newborn child of a Covered Employee will be considered eligible and will be covered from the moment of birth for thirty-one (31) days for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity and Routine Newborn Care. Written notification must be received by the Plan Administrator within thirty-one (31) days after the child's date of birth for continued coverage. A newborn of a Dependent child is not eligible for this Plan unless the newborn child meets the definition of an eligible Dependent.
2. A new spouse of a Covered Employee and any dependent children of a new spouse who meet the Plan's definition of "Dependent" will be considered eligible and will be covered on the date of the Covered Employee's marriage, provided the spouse and/or his/her children are enrolled as Dependents of the Covered Employee within thirty-one (31) days after the date of marriage.
3. A child under the age of eighteen (18) placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child.
4. A child of a non-custodial parent, who is a Covered Employee or an Employee's covered Dependent spouse, will be considered eligible if the Covered Employee or Employee's covered Dependent spouse is required to provide benefit coverage for the child in accordance with applicable requirements of a Qualified Medical Child Support Order (QMCSO).
5. A Dependent child will be considered eligible if child is unmarried, under nineteen (19) years of age or twenty-five (25) years of age if a Full-time Student and primarily dependent upon the Covered Employee for support. Proof of Full-time Student status is required. See definition of Full-time Student.
6. If a Dependent of a Covered Employee is to be enrolled in the Plan, other than at the time of his/her eligibility or birth, adoption, court order or marriage to the Covered Employee, that Dependent would be considered a Late Enrollee unless he/she qualifies for a Special Enrollment.
7. A spouse and/or child of a Covered Employee who previously was not eligible for the Plan will be considered eligible on the date he/she meets the Plan's definition of "Dependent."

The Eligibility provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) effective August 10, 1993 as the same may be later amended.

If both the husband and wife are employed by the Employer, and both have Dependent(s) eligible for coverage, either the husband or wife, but not both, may elect Dependent coverage for their eligible Dependents.

NOTE: A Dependent, who was enrolled on the most recent restated date of this Plan and who was covered by this Plan and met the Plan's prior definition of Dependent, is also considered eligible to continue coverage subject to the terms and conditions of this Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS/PLACEMENT FOR ADOPTION

The Plan will comply with the rules relating to adopted children, children placed for adoption, Qualified Medical Child Support Orders ("QMCSO"), and National Medical Support Notices ("NMSN"). The Plan will use the following rules related to children placed for adoption, QMCSOs and NMSNs.

This Plan will provide benefits in accordance with the applicable requirements of any QMCSO or NMSN. A QMCSO is a medical child support order of a court or of certain administrative agencies that creates, recognizes or assigns to a child of a Plan Participant the right to receive health benefit coverage under the Plan. A NMSN is an order issued by a state agency requiring the Plan to cover a child. To be qualified, a medical child support order must comply with state and federal laws and contain the following:

1. The name and last known mailing address (if any) of both the Plan Participant and the child covered under the order except that, to the extent provided in the order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient.
2. A reasonable description of the type of coverage to be provided by the Plan for each child (or the manner in which the type of coverage will be determined).
3. The period of coverage to which the order applies.

In addition, a QMCSO or NMSN will generally not be considered qualified if it requires the Plan to provide certain benefits or options which are not otherwise provided by the Plan. The Plan Administrator will notify the Plan Participant of the receipt of a medical child support order and the procedures for determining whether it is a Qualified Medical Child Support Order or a NMSN. The Plan Administrator will then determine within a reasonable period of time whether the medical child support is a QMCSO or NMSN.

Plan Participants may request and receive, free of charge, a copy of Plan procedures relating to QMCSOs and NMSNs.

This Plan will also provide benefits to Dependent children placed for adoption on the same basis as natural children even prior to the adoption becoming final. A child will be considered "Placed for Adoption" with a Plan Participant if the Plan Participant has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child. For this reason, if a child is placed with a Plan Participant for adoption by an adoption agency or other entity, the Plan Participant must provide to the Plan Administrator documentation (e.g., signed court order) that the adoption agency or other entity had legal custody of the child on the date that the child was placed with the Plan Participant for adoption. The Plan Administrator will determine within a reasonable period of time whether a child has been "Placed for Adoption."

The Plan Administrator has final, discretionary authority to determine: (1) whether a medical child support order qualifies as a QMCSO or NMSN; and (2) whether a child has been "Placed for Adoption."

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

An eligible Employee, properly enrolled in the Plan, will be referred to as a "Covered Employee."

Each Employee's coverage under the Plan shall become effective on his/her Date of Eligibility, which is the date the Employee completes the thirty (30) day Waiting Period provided written application for coverage is made on or before his/her Date of Eligibility or within thirty-one (31) days after the Date of his/her Eligibility.

DEPENDENT EFFECTIVE DATE

Dependent coverage under the Plan shall become effective on the date of Dependent Eligibility, provided the Employee makes written application for Dependent coverage on or within thirty-one (31) days after the date of Dependent Eligibility subject to the enrollment requirements as follows:

1. In order to become covered under the Plan, eligible Dependents must be identified on an enrollment/change form.
2. If the Employee makes written request for Dependent coverage on or before his/her own Date of Eligibility or within the thirty-one (31) days immediately following his/her own Date of Eligibility, then each eligible Dependent(s) coverages will become effective the same date the Employee's coverage is effective.
3. If the Covered Employee makes written request to add a Dependent child to the Plan in accordance with a Qualified Medical Child Support Order (QMCSO), the effective date of coverage for the Dependent child will be the date specified in the QMCSO.
4. If the Covered Employee makes written request to add a Dependent spouse and/or child who previously was not eligible for the Plan, the effective date of coverage is the date the individual meets the Plan's definition of Dependent.

LATE ENROLLEE

An Employee or Dependent who enrolls in the Plan more than thirty-one (31) days after the Date of his/her initial Eligibility is considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

The Plan provides Special Enrollment rights and Special Enrollment Periods for Employees and their Dependents who previously declined to enroll in the Plan and who remain eligible for the Plan.

SPECIAL ENROLLMENT PERIOD FOR LOSS OF OTHER COVERAGE

Eligible Employees and eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose other sources of coverage (other than for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be completed within thirty-one (31) days after the date other coverage ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Individuals, who previously declined coverage in the Plan because of other coverage, may be eligible to enroll in the Plan during the Special Enrollment Period if other coverage is lost due to one of the following:

1. The other coverage terminated as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. COBRA continuation coverage was exhausted; or
3. Coverage was lost because Employer contributions were terminated.

Loss of coverage due to an individual's failure to pay premiums or contributions does not qualify for a Special Enrollment Period.

Length of Special Enrollment Period for Loss of Other Coverage

A request for a Special Enrollment due to loss of other coverage must be made no later than thirty-one (31) days after the exhaustion of COBRA coverage or the termination of other non-COBRA coverage as a result of the loss of eligibility or termination of Employer contributions toward that coverage.

Effective Date of Coverage Following Special Enrollment for Loss of Other Coverage

The effective date of coverage for an eligible Employee and his/her eligible Dependents who make written application for coverage during a Special Enrollment Period will be the day following the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

1. An Employee who previously declined enrollment and who remains eligible for coverage under the Plan has Special Enrollment rights when the eligible Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption.
2. A new spouse is entitled to Special Enrollment rights when he/she becomes the spouse of a Covered Employee or when a child becomes a Dependent of a Covered Employee through birth, adoption or placement for adoption.
3. A person is entitled to Special Enrollment rights when the person becomes a Dependent of a Covered Employee through marriage, birth, adoption or placement for adoption.
4. An Employee who previously declined enrollment and remains eligible for coverage under the Plan has Special Enrollment rights for himself/herself and the Employee's spouse if a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

Length of Special Enrollment Period for New Dependents

A request for a Special Enrollment due to acquiring New Dependents must be made no later than thirty-one (31) days after the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage Following New Dependent Special Enrollment

The effective date of coverage for an eligible Employee and his/her eligible Dependents who make written application for coverage during a New Dependent Special Enrollment Period will be as follows:

1. In the case of marriage: the date of marriage;
2. In the case of a Dependent's birth: the date of birth; or
3. In the case of a Dependent's adoption or placement for adoption: the date of such adoption or placement for adoption

NOTE: Proof of Qualifying Event for Special Enrollment will be required.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE HEALTH PLAN

The Annual Open Enrollment Period for the Plan is the month of September of each year for coverage to become effective October 1, provided written application for coverage is made on or before the end of the Open Enrollment Period or within thirty-one (31) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. Re-enrollment for Covered Employees is not required unless a Covered Employee requests a coverage change.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless the person qualifies for a Special Enrollment or if there is a Status Change.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written application for coverage under the Plan more than thirty-one (31) days after the Date of his/her Eligibility;
2. He/she was not eligible for a Special Enrollment; or
3. He/she failed to enroll by the end of a Special Enrollment Period.

Effective Date of Coverage for Employee Late Enrollees

The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written application for Dependent coverage after the thirty-one (31) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;
2. The Covered Employee makes written request to add a Dependent after the thirty-one (31) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or
3. An eligible Employee (not currently enrolled in the Plan) makes written request to add a new Dependent more than thirty-one (31) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees

The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.

COVERAGE CHANGES

FOR EMPLOYEES PARTICIPATING IN THE SECTION 125 PLAN

Contributions to the Plan can be made on a "Salary Reduction" basis under Section 125 of the Internal Revenue Code. This allows premium contributions to be withheld from Employee's paycheck on a "pre-tax" basis before any Federal Income Tax or Social Security Tax is calculated.

The Annual Election Period for the Section 125 Plan is the same as the Annual Open Enrollment Period for the Employee Health Plan. This is the month of September of each year for an effective date of October 1. Once an election is made to participate, this election can only be changed during the next year's Annual Election Period for the Section 125 Plan.

An exception to this annual election only rule is allowed if there is a change in status due to certain events including any of the following:

Status Changes

- Marriage
- Divorce or legal separation (in those states recognizing legal separation)
- Birth or adoption of a child
- Death of spouse or child
- Commencement of spouse's employment
- Termination of spouse's employment
- Significant cost or coverage changes for Employee or spouse
- Change from part-time to full-time employment (or vice-versa)/reduction or increase in hours
- Unpaid leave of absence
- Change in the residence or worksite
- Dependent satisfies or ceases to satisfy the eligibility requirements for coverage
- Qualified Medical Child Support Order (QMCSO)
- Entitlement to or loss of eligibility for Medicare or Medicaid

An election change may be made only if one of these recognized changes in status will result in the gain or loss of eligibility for coverage of the Employee, the Employee's spouse or Dependent.

A written request for addition or deletion of coverage due to a Status Change must be made within thirty-one (31) days of that change or the exception will not apply.

Effective Date of Coverage Following Status Change

Most Status Changes qualify for Special Enrollment, see the Employee and Dependent Special Enrollment Periods section.

If there is a Status Change which does not qualify for a Special Enrollment Period as outlined in the Employee and Dependent Special Enrollment Periods, the effective date of coverage will be the date of the Status Change.

FOR EMPLOYEES NOT PARTICIPATING IN THE SECTION 125 PLAN

A request for coverage change (addition or deletion of coverage) can also be made when premium contribution is withheld from the Employee's paycheck on an after-tax basis. A written request for deletion of coverage can be made by signing and completing a Change Form. Deletion of coverage is subject to the Plan's Termination provisions. A written request for addition of coverage can be made subject to the Plan's Annual Open Enrollment, Eligibility, Effective Date, Special Enrollment Period and Late Enrollee provisions.

TERMINATION OF COVERAGE

EMPLOYEE TERMINATION

Employee's coverage shall automatically terminate immediately upon the earliest of the following dates:

1. The date the Employee's employment terminates;
2. The date the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The date the Employee fails to make any required contribution for coverage;
4. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
5. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
6. The date the Employee requests termination of coverage;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved leave of absence from work;
9. The date the covered Retiree becomes entitled to Medicaid/Medicare or seven (7) years following the date of retirement; or
10. The date the Employee dies.

DEPENDENT TERMINATION

The Dependent coverage of an Employee shall automatically terminate immediately upon the earliest of the following dates:

1. The date the Dependent ceases to be an eligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The date the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved leave of absence from work;
9. The date the Covered Employee retires; or
10. The date the Employee dies.

Coverage may be continued under COBRA, but continuation of coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a Covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event (loss of coverage due to divorce, legal separation, or a Dependent child ceasing to qualify as a Dependent). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage. See Continuation of Group Health Coverage (COBRA) section for further information.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272 and the Employer's Section 125 Plan.

COVERAGE DURING LEAVE OF ABSENCE

If, after depletion of sick leave and vacation time, active work ceases due to a Workers' Compensation related Illness or Injury or an approved leave of absence subject to the Family and Medical Leave Act (FMLA) or approved Family, Medical, Disability and/or other temporary leave required by applicable state law, the Plan Administrator may, while Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work due to:

1. Approved Medical and Disability Leave if the Leave of Absence relates to Workers' Compensation, provided any required Employee contributions are made; or
2. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks provided any required Employee contributions are made; or
3. Approved Family, Medical, Disability and/or other temporary leave required by applicable state law for up to the minimum amount of time required by such state law provided any required Employee contributions are made.

The Workers' Compensation related Medical and Disability Leave is not concurrent with the twelve (12) week approved Family and Medical Leave (FMLA) or the minimum amount of time required by an approved Family, Medical, Disability and/or other temporary leave required by applicable state law.

If Employee has not returned to Full-time Employment after completion of an approved Leave of Absence, or if Employee notifies Employer that he/she will not be returning to Full-Time Employment following the Leave of Absence, coverage terminates and COBRA continuation becomes available on the basis of reduction in hours. See Continuation of Group Health Coverage (COBRA) section. Failure of Employee to make any required Employee contributions during an approved Leave of Absence will also result in termination of coverage.

Family and Medical Leave is subject to the requirements of the Family and Medical Leave Act (FMLA).

ACTIVE DUTY IN THE ARMED FORCES

If a Covered Employee and/or his/her covered Dependent(s) would lose Plan coverage as a result of the Employee being called for active duty in the armed forces of the United States, such a reduction in hours (or termination of employment) would be a COBRA Qualifying Event. Any coverage mandated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) will run concurrently with federally mandated COBRA coverage. See Continuation of Group Health Coverage (COBRA) section.

REINSTATEMENT OF COVERAGE

A terminated Employee on COBRA who is rehired and returns to work does not have to satisfy the employment Waiting Period and Pre-existing Condition Exclusion provisions.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and qualifies for Military Leave under Uniformed Services Employment and Reemployment Rights Act (USERRA) will be reinstated on the date he/she resumes employment with the Employer provided that such resumption of employment is within the time period specified in USERRA. The Pre-existing Condition Exclusion Limitation will not apply to an Employee who is entitled to and is reinstated immediately after military service under USERRA. (This waiver does not provide coverage for an Illness or Injury caused or aggravated by military service as determined by the Veterans Administration).

The Reinstatement provision is subject to the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

NOTE: If an Employee or Dependent has a change in eligibility while covered under this Plan (i.e., from Employee to Dependent, from Employee to COBRA Participant; from COBRA Participant to active Employee, etc.) and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous with respect to the Pre-existing Condition Exclusion Limitation and Eligibility Waiting Period.

FAMILY AND MEDICAL LEAVE (FMLA)

All Employers employing at least fifty (50) workers within a seventy-five (75) mile radius of the work place must provide eligible Employees with up to twelve (12) weeks of job-protected leave of absence during a twelve (12) month period, as determined by the Employer, generally for any of the following situations:

- The birth or adoption of a child;
- The serious illness of the Employee's spouse, child, or parent; or
- The Employee's own disabling serious illness.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: an Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee Benefits may include:

▪ group life	▪ medical	▪ dental
▪ educational benefits	▪ annual leave	▪ pensions
▪ sick leave	▪ disability	

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. This means that new Waiting Periods and Pre-existing Condition Limitations are not applied. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee Benefits may or may not be applicable to every Employer's Plan of Benefits. This section is intended as a summary of the Family and Medical Leave Act of 1993 (FMLA) effective August 5, 1993, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Employer's Policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE

(Applies to Medical and Prescription Drug Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2 percent.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

<u>Qualified Beneficiary</u>	<u>Qualifying Event</u>	<u>Maximum Coverage Period</u>
Covered Employee	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Covered Dependent	Loss of coverage due to Employee's termination of employment (other than for gross misconduct), reduction in hours or Employee's retirement	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction of hours	29 months
Covered Dependent	Loss of coverage due to divorce, legal separation, or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent child losing eligibility as a Dependent child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare See Special Medicare Entitlement Rule section.	36 months

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

*SOCIAL SECURITY DISABILITY

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment, reduction in hours or if a Covered Employee or a covered Dependent becomes disabled at any time during the first sixty (60) days of COBRA continuation coverage, the disabled person may continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, not later than eighteen (18) months after the date of loss of coverage due to termination of employment or reduction in hours, that the individual is disabled and the individual notifies the Plan Administrator of the determination within sixty (60) days after the determination is made.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150 percent of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on Covered Employee's loss of coverage due to termination of employment or reduction of hours and a second Qualifying Event (divorce, legal separation, death or a Dependent child losing eligibility as a Dependent child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2002, the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2004 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2005.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the Covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential 18 month COBRA continuation period for all Qualified Beneficiaries. While the Covered Employee is only entitled to 18 months of COBRA continuation coverage, the other Qualified Beneficiaries (spouse and/or dependent children) are entitled to 18 months or 36 months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event (loss of coverage due to divorce, legal separation, or a Dependent child losing eligibility as a Dependent child). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage is elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of fifty dollars (\$50) or ten percent (10%) of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously discussed upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election, unless the other plan contains any exclusion or limitation with respect to a Pre-existing Condition of the individual;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a child who is born to, or a child who is placed for adoption with the Covered Employee Qualified Beneficiary. If the newborn or adopted child is added to the Covered Employee's COBRA continuation coverage, then unlike a new spouse, the newborn or adopted child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction of hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, when applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

EXPANDED COBRA AND HIPAA BENEFIT PROTECTION TRADE BILL OF 2002

The Trade Bill of 2002 expanded COBRA and HIPAA benefit protections for certain COBRA Qualified Beneficiaries who lose jobs and health benefits as a result of American jobs lost to overseas business or those affected by increased foreign imports.

Eligible COBRA Qualified Beneficiaries: To be eligible for TAA (Trade Adjustment Assistance) Benefits, an Employee must have been laid off or put on a reduced work schedule (hours of work reduced to 80% or less of average weekly hours and wages reduced to 80% or less of average weekly wage) on or after the impact date and before the ending date of certification.

In order for the U.S. Department of Labor to issue a Certification Regarding Eligibility to apply for Worker

Adjustment Assistance, the following requirements must be met:

1. that workers have been totally or partially laid off; or
2. that sales or productions have declined; or
3. that increased imports have contributed importantly to worker layoffs.

Once the U.S. Department of Labor issues a Certification Regarding Eligibility, trade affected workers may apply for benefits under the TAA program.

If certification is received, then affected Qualified Beneficiaries are eligible for the expanded COBRA/HIPAA protections as follows:

65% COBRA Premium Tax Credit: While the tax credit is technically available back to January 1, 2002, a TAA Qualified Beneficiary can only claim the tax credit for months beginning 90 days after the enactment of the act on August 6, 2002 (November 6, 2002).

60-Day COBRA Election Period and New 18 Month Period: Since January 1, 2002, many TAA Qualified Beneficiaries have been offered the opportunity to elect continuation coverage, but did not do so because of the cost. In an effort to provide the tax credit to as many Qualified Beneficiaries as possible, Congress added a special 60-day COBRA election period to the Trade Bill.

HIPAA 63-Day Break in Coverage Rule Waived: When there is a break in coverage of more than 63 days between the time the original coverage ended and the time the COBRA continuation coverage would begin, current federal HIPAA rules would leave the Qualified Beneficiary subject to Pre-Existing Condition Exclusion provisions. Under the new Trade Bill provisions, under the above circumstances, the break in coverage would not be considered a break in coverage for purposes of portability.

USERRA CONTINUATION OF COVERAGE

These provisions summarize continuation of coverage under this Plan for employees absent from work due to military service. The Plan intends to provide benefits as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and any amendments thereof.

As an Employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

If you choose Continuation of Coverage, the Employer is required to offer you coverage identical to that provided under the Plan prior to your military leave. Like COBRA coverage, such coverage may be continued for up to eighteen (18) months during a period of military service. The cumulative length of the Employee's absences cannot exceed five (5) years.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type, but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases determined based on the content in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Accidental Injury: See definition of "Injury."

Actively at Work: As applied to an Employee: the Employee will be considered "Actively at Work" on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed "Actively at Work" on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was "Actively at Work" on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Expense: The term "Allowable Expense" means any necessary item of expense, for which the charge is Usual and Customary, or is based on the contracted fee schedule of an alternate care delivery system.

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 twenty-four (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.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, excluding the Calendar Year Deductible, other Deductibles, Copayments and any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Authorized Representative: Person authorized to act on behalf of Claimant for a benefit claim or appeal of an Adverse Benefit Determination.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: That portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of the Calendar Year Deductible which are to be paid by the Employee.

Benefit Period: The time period shown on the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the period so established; or
2. The day the Maximum Lifetime Benefit applicable to the Covered Person becomes payable; or
3. The day the Covered Person ceases to be covered for Major Medical Expense Benefits.

Birthing Center: A facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Certificate of Coverage (COC): A certificate verifying an individual's Creditable Coverage.

Chemical Dependency: The abuse of or psychological or physical dependency on or addiction to alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance in Chapter 481 of the Texas Health and Safety Code or equivalent State code where applicable.

Chemical Dependency Treatment Center: A facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which facility is also:

1. Accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations sponsored by the A.M.A. and A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit claims.

Claim Determination Period: A Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom claim is made, has been covered under this Plan.

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Close Relative: Includes the spouse, mother, father, sister, brother, child, or in-laws of the Covered Person.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect continuation coverage under COBRA. This sixty (60) day period begins no later than:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect continuation coverage under this Plan.

COBRA Qualified Beneficiary: Any former Employee or Dependent covered under this Plan on the day before the Qualifying Event, who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after any applicable Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person's or Family's Annual Out-of-Pocket Maximum.

College: See definition of "University."

Complications of Pregnancy: A disease, disorder or condition which is diagnosed as distinct from normal Pregnancy but adversely affected by or caused by Pregnancy. This includes, but not limited to:

1. Inter-abdominal surgery, including cesarean section;
2. Premicious vomiting (hyperemesis gravidarum);
3. Toxemia with convulsions (eclampsia);
4. Extra-uterine Pregnancy (ectopic);
5. Postpartum hemorrhage;
6. Rupture or prolapse of the uterus;
7. Spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible; or
8. Similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will not include:

1. Elective abortion;
2. False labor;
3. Occasional spotting;
4. Physician prescribed rest;
5. Morning Illness; or
6. Similar conditions associated with the management of a difficult Pregnancy.

Concurrent Review: The Utilization Review Company's review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Congenital Anomaly: Birth defect.

Convalescent Nursing Facility: An institution or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides twenty-four (24) hour-per-day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;

5. It is not, other than incidentally, a place for rest, the aged, drug addicts, Chemical Dependency, mentally retarded individuals, custodial or educational care, or care of mental disorders; and
6. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature.

Convalescent Period: A period of time commencing with the date of confinement by a Covered Person to a Convalescent Nursing Facility. Such confinement must meet all of the following conditions:

1. Such confinement must commence within fourteen (14) days of being discharged from a Hospital;
2. Said Hospital confinement must have been for a period of not less than three (3) consecutive days; and
3. Both the Hospital and convalescent confinements must have been for the care and treatment of the same illness or injury.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of one-hundred-twenty (120) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

Copayment or Copay: 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 Maximum.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Medical Expenses: The Usual and Customary (U&C) charges and/or contracted PPO charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an illness or injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

Covered Person: An Employee, a Dependent, a Retiree, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

Creditable Coverage: Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare. Creditable Coverage does not include coverage consisting solely of dental or vision benefits. A Certificate of Coverage (COC) is proof of Creditable Coverage.

Crisis Stabilization Unit: A 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportion. Treatment provided through Crisis Stabilization Units will be reimbursed for facilities licensed or certified by the Texas Department of Mental Health and Mental Retardation or the equivalent agency of another state.

Custodial Care: 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, 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.

Date of Eligibility: The date the Employee becomes eligible for the Plan.

Date of Hire: The Employee's first day of full-time employment with the Employer.

Deductible: A specified dollar amount of Non-PPO Covered Expenses which must be incurred during a Calendar Year before any other Non-PPO Covered Expenses can be considered for payment according to the applicable Benefit Percentage. "Deductible" also means that dollar amount of the expense of a particular procedure or Covered Expense for which it is indicated in the Schedule of Benefits that a special Deductible will apply. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Dependent: The term "Dependent" means:

- A. The Covered Employee's legal licensed spouse who is a resident of the same country in which the Covered Employee resides. Such spouse must have met all requirements of a valid marriage contract in accordance with the laws of the state of such parties. **NOTE:** Proof of legal status may be required by the Plan Administrator.
- B. The Covered Employee's child who meets all of the following conditions:
 - 1. Is a resident of the same country in which the Covered Employee resides;
 - 2. Is unmarried;
 - 3. Is either a:
 - a. natural child; or
 - b. step-child; or
 - c. child who has been placed under the legal guardianship of the Covered Employee; or
 - d. child under the age of eighteen (18) who has been legally adopted or placed for adoption with the Covered Employee; and
 - 4. Is in the custody of, residing with and financially dependent for primary support upon the Covered Employee. This condition is waived if the child is a natural child or a legally adopted child or if the Covered Employee or Employee's covered Dependent spouse is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) or divorce decree for a child not in his/her custody or not wholly dependent upon him;
 - 5. Is carried as an exemption on the Covered Employee's federal income tax return. This condition is waived if the child is a natural child or a legally adopted child or if the Covered Employee or Employee's covered Dependent spouse is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) or divorce decree for a child not carried as an exemption on the Covered Employee's federal income tax return; and
 - 6. Is less than nineteen (19) years of age. This requirement is waived if the child is at least nineteen (19) years of age but less than **twenty-five (25) years of age**, unmarried and is primarily dependent upon the Covered Employee for support, and is a regular Full-time Student at a qualified educational institution. See definition of Full-time Student.

The age requirement above is also waived for any unmarried mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Covered Employee for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator at the time of enrollment or within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement. In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

NOTE: Proof of Dependent eligibility may be required.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Durable Medical Equipment: Equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

Elective Surgical Procedure/Elective Surgery: A non emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Eligible Employee: An Employee who has satisfied the applicable Waiting Period and who is employed by the Employer on a full-time basis of at least an average of thirty (30) hours per week, not to include seasonal or temporary employees.

Employee: Any person who is regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Employer: City of Terrell.

Enrollment Date: The Enrollment Date in the Plan for an eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan. The term "Enrollment Date" is used to determine the Pre-existing Condition Exclusion and look-back periods and does not define Date of Eligibility for the Plan.

Experimental/Investigational: Any treatments, procedures, drugs, medicines or related expenses for which one or more of the following is true:

1. The device, drug, medicine or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and full approval has not been given at the time the device, drug, medicine or biological product is furnished;
2. Reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing Phase I, II or III clinical trial or under scientific study to determine its maximum tolerated doses, toxicity, safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis;
3. The Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety; or
4. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means published reports and articles in authoritative and scientific literature; written protocol(s) used by treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or another facility studying substantially the same treatment, procedure, device, drug or medicine.

Medical treatment which is not considered standard treatment (i.e., not of proven benefit for a particular diagnosis) by the majority of the medical community or by Medicare/Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational.

Family: A Covered Employee and his/her eligible Dependents.

Family and Medical Leave: A leave of absence pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Free-standing Facility: An independent facility which provides medical services on an Outpatient basis, usually not affiliated with a Hospital, i.e., Ambulatory Surgical Center, imaging center.

Full-Time Employment: A basis whereby an Employee is employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Full-time Student: A Covered Employee's Dependent child who is enrolled in and regularly attending a "qualified educational institution." Qualified educational institutions shall mean high schools, junior colleges or other two-year colleges granting two-year degrees, Universities or colleges granting four-year degrees or post-graduate degrees, proprietary schools such as business colleges, professional schools, trade and technical schools that are established as other than evening schools exclusively. "Full-time Student" status for all qualified educational institutions shall be determined by the institution attended by the student.

NOTE: Proof of Full-time Student status is required.

Cessation of full-time school attendance shall terminate coverage with respect to the student; however:

1. If cessation is due to vacation, coverage shall terminate on the date the school reconvenes;
2. If cessation is due to graduation, coverage shall terminate at the end of the month following such graduation;
3. If cessation is due to disability that prevents the student's full-time school attendance, coverage shall terminate on the first day of the school's next regular session following the date established by a Physician's written statement to the Plan Administrator that the student is not capable of full-time school attendance;
4. Or if a child is a Full-time Student at the beginning of an academic term and remains enrolled in the academic facility but reduces the number of enrolled hours to less than that of full-time school attendance, coverage shall terminate on the date the school reconvenes for the subsequent academic term;
5. If, during the last academic term prior to graduation with an undergraduate or graduate degree, a student is only required to carry the remaining number of hours necessary to complete a degree plan, the student is still considered a Full-time Student even if the number of enrolled hours is less than that of a full-time school attendance;
6. If a Dependent child becomes nineteen (19) years of age during the winter or summer semester breaks following a semester of full-time school attendance immediately preceding the nineteenth (19th) birthday, coverage will continue until the next semester begins. If not enrolled as a Full-time Student in the next semester following the nineteenth (19th) birthday, coverage terminates; and
7. **In no event will a person be a Full-time Student after attainment of age twenty-five (25).**

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance, set standards for Pre-existing Condition exclusion periods and changed health status eligibility provisions for employee health plans.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Home Health Care Agency: The term "Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the patient's home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

Home Health Care Plan: The term "Home Health Care Plan" means a program for care and treatment of the Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as Inpatient in a Hospital or other Inpatient facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: This term means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician's or other provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider: An entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy.

Homebound: "Homebound" means that the patient's medical condition is such that it significantly restricts the ability to leave the home and that the patient is unable to drive him/herself.

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

Hospice Benefit Period: A specified amount of time during which the Covered Person undergoes Hospice care. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earlier of six (6) months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof may be required by the Claims Administrator before such a new benefit period can begin.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured

and sick persons by or under the supervision of a staff of Physicians. If primarily a facility for the treatment of Mental and/or Nervous Disorders, drug addiction and/or Chemical Dependency, such facility must have a bona fide arrangement by contract or otherwise with a Hospital to perform such Surgical Procedures as may be required;

2. It continuously provides twenty-four (24) hours per day nursing service by registered professional nurses under the supervision of Physicians; and
3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital Miscellaneous Expenses: The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person, which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness: A bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Immunization: The protection of individuals or groups from specific diseases by vaccination or the injection of immune globulins.

Incurred Expenses: Those services and supplies rendered to a Covered Person. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

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

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice or convalescent facility for treatment or observation; charges must be incurred for room and board or observation for a period of at least twenty-four (24) hours.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty-one (31) days after the date of his/her eligibility and who was not eligible for a Special Enrollment Period or who failed to enroll by the end of a Special Enrollment Period.

Licensed Practical Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modification or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Amounts: Any Lifetime Maximum amounts or Calendar Year Maximum amounts or any Maximum amounts otherwise specified are applicable to the total expenses paid during all Plan Years whether or not the Covered Person has been continuously covered under this Plan and any prior Plan Years under this Employer's Plan.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body.

Medical Emergency: An Illness or Injury of such a nature that failure to get immediate medical care could put a person's life in danger or cause serious harm to bodily functions. Some examples of a Medical Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple

injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an illness. Some examples of conditions that are not generally considered a Medical Emergency are: colds, influenza, ear infections, nausea or headaches.

Medical Review Specialist: An organization under contract to the Plan Administrator to provide the services required under the Cost Containment Features of Hospital Admission Notification/Continued Stay Review/Case Management. The Plan Administrator will furnish the name, address, and phone number of the Medical Review Specialist.

Medically Necessary/Medical Necessity: A "Medically Necessary" treatment, device, supply, medication or test is one which is generally accepted and used by the medical community and is appropriate for the condition being diagnosed or treated. Information which may be used to determine Medical Necessity may include independent Physician review, medical literature, results of clinical trials, nationally accepted Utilization Review criteria and conclusions reached by professional, medical or regulatory organizations. Not Medically Necessary is a treatment, device, supply, medication or test which does not contribute to the diagnosis of or therapeutic improvement for the condition in question, although well-being may be generally enhanced by it. The item can be outmoded or unproved as having diagnostic capability or effect on the condition in question. An independent Physician designated by the Utilization Review Company will review potential cases deemed not Medically Necessary.

Medicare Benefits: All benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as amended, from time to time.

Mental Health Parity Act of 1996: Signed into law September 26, 1996 effective for plan years beginning on or after January 1, 1998.

Mental and Nervous Disorders: Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Midwife: A licensed Registered Nurse (R.N.) who is certified as a Nurse Midwife (C.N.M.) by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under state regulations.

Minor Emergency Medical Clinic: A Free-standing Facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on the premises of or in conjunction with, or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): This added a new section restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the accident.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services.

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) effective August 10, 1993.

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Oral Surgery: Maxillofacial Surgical Procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic: An external device intended to correct a defect in form or function of the human body.

Out-of-Area: "Out-of-Area" applies to a Covered Person living or traveling outside of the geographical zip code area serviced by the Preferred Provider Organization (PPO).

Outpatient: A patient who receives medical services at a Hospital, but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a free-standing independent facility such as an Ambulatory Surgical Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or drug use or abuse; provides detoxification services needed with its effective treatment program; provides infirmity level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician, and meets applicable state and federal, if any, licensing standards.

Outpatient Psychiatric Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Part-time Employee: Any Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility Section of this Plan Document.

Physical Therapy: Management of the patient's movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Physically or Mentally Handicapped: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Placement for Adoption: A child under the age of eighteen (18) placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: The City of Terrell, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

Plan Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant: Eligible Employee, eligible Dependent, eligible Retiree, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: The City of Terrell.

Plan Year: October 1 through September 30 of the next Calendar Year. The Plan Year is the year on which Plan records are kept.

Post-Service Claim: Any claim for which payment is requested for medical care already rendered to the Claimant.

Practitioner: A Physician or person acting within the scope of applicable state licensure/certification requirements includes the following:

1. Advance Practice Nurse (A.P.N.)
2. Audiologist
3. Certified Nurse Midwife (C.N.M.)
4. Certified Operating Room Technician (C.O.R.T.)
5. Certified Registered Nurse Anesthetist (C.R.N.A.)
6. Certified Surgical Technician (C.S.T.)
7. Doctor of Chiropractic (D.C.)
8. Doctor of Dental Medicine (D.M.D.)
9. Doctor of Dental Surgery (D.D.S.)
10. Doctor of Medicine (M.D.)
11. Doctor of Optometry (O.D.)
12. Doctor of Osteopathy (D.O.)
13. Doctor of Podiatry Medical (D.P.M.)
14. Licensed Clinical Social Worker (L.C.S.W.)
15. Licensed Occupational Therapist
16. Licensed or Registered Physical Therapist
17. Licensed Professional Counselor (L.P.C.)
18. Licensed Surgical Assistant (L.S.A.)
19. Master of Social Work (M.S.W.)
20. Physician Assistant (P.A.)
21. Psychologist (Ph.D., Ed.D., Psy.D.)
22. Registered Nurse First Assistant (R.N.F.A.)
23. Registered Nurse Practitioner (R.N.-FNP)
24. Speech Language Pathologist

Pre-existing Condition: Any physical or mental illness or injury for which the Covered Person received medical care, advice, diagnosis or treatment, or for which a Physician was consulted or for which medical expenses were incurred or for which a Covered Person has taken prescribed drugs or medicines during the **six (6)** months immediately prior to the Covered Person's Enrollment Date in the Plan.

Preferred Provider Organization (PPO): An alternate health care delivery system with which Plan Administrators may contract to provide comprehensive medical care for Employees. A PPO is a network of individual Physicians, Hospitals and other providers who accept pre-negotiated, discounted fees for services rendered. Employee participation is encouraged by plan design for improved benefits when network providers are used. Employees have flexibility under PPO arrangements in which there is a choice of network or non-network providers.

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Drugs or medicines which are prescribed by a Qualified Prescriber for the treatment of Illness, Injury or Pregnancy.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse or Licensed Practical Nurse while patient is not confined in a Hospital.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Psychiatric Treatment Facility: A mental health facility which:

1. Provides treatment for individuals who suffer from acute Mental and Nervous Disorders;
2. Uses a structured psychiatric program with individual treatment plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a medical child support order that satisfies the following requirements to be a Qualified Medical Child Support Order:

1. The name and last known mailing address of the Plan Participant.
2. The name and address of each alternate recipient. "Alternate recipient" means any child of a Plan Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Plan Participant.
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined.
4. The period for which coverage must be provided.
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body which are lost or impaired due to an Injury or Illness.

Registered Nurse: An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory, or part-time care services, or an

institution which primarily provides treatment of Mental and Nervous Disorders, Chemical Dependency, or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Residential Treatment Center: Facility that provides twenty-four (24) hour treatment for Chemical Dependency, Drug and Substance Abuse or mental health problems on an Inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services. A Residential Treatment Facility is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant state and local laws.

Residential Treatment Center for Children and Adolescents: A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council of Accreditation, the Joint Commission on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Retiree: A former Covered Employee of the Employer who has meets the definition of a Retiree under the Texas Municipal Retirement System.

Retrospective Review: A determination by the Utilization Review Company that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, or Convalescent Nursing Facility, Rehabilitation Facility or other covered facilities as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn child for nursery room and board, related expenses following birth, including newborn hearing tests and Physician's pediatric services including circumcision. This term does not apply to a newborn child's diagnosed illness.

Semi-Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other facility providing services on an Inpatient basis in which at least two patient beds are available per room.

Serious Mental Illness: The term "Serious Mental Illness" is defined as any one of the following eight (8) categories:

- a. Schizophrenia;
- b. Paranoid and other psychotic disorders;
- c. Bipolar disorders (mixed, manic and depressive);
- d. Major depression disorders (single episode or recurrent);
- e. Schizo-affective disorders (bipolar or depressive);
- f. Pervasive Development disorders;
- g. Obsessive Compulsive disorder; and
- h. Depression in Childhood and Adolescence.

Significant Break in Coverage: A period of sixty-three (63) consecutive days or more during which the Employee or Dependent did not have any Creditable Coverage. Waiting Periods are not considered in determining Significant Breaks in Coverage.

Skilled Nursing Facility/ Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing service to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Special Enrollee: An Eligible Employee and his/her eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty-one (31) days in which an Employee or Dependent who previously declined enrollment in the Plan by signing a Waiver of Coverage, can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of other coverage (other than for cause or non-payment of premium); or
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption.

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic disease process.

Substance Abuse: Use of or addiction to alcohol, drugs or controlled substances resulting in Chemical Dependency, which is psychological and/or physical dependence on same.

Surgery: A branch of medicine concerned with the correction of physical defects, the repair of Injuries, and the treatment of disease. Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

Surgical Procedure: The term "Surgical Procedure" means:

1. Incision, excision, debridement or cauterization of any organ or part of the body, or the suturing of a wound;
2. Manipulation reduction of a fracture or dislocation, or the manipulation of a joint, including application of a cast or traction;
3. Removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body;
4. Induction of artificial pneumothorax and injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilation and curettage; and
7. Biopsy.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint Syndrome (TMJ): Also known as myofascial pain-dysfunction syndrome, is a disorder that affects the two joints at either side of the jaw (the temporomandibular joints).

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of an Employee, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. In the case of a Dependent or a COBRA Qualified Beneficiary or Retiree, from performing the normal activities of a person of that age and sex in good health.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A federal law which applies to persons who have been absent from work because of “service in the uniformed services.” “Uniformed services” consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or emergency. “Service” in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work for an examination to determine a person’s fitness for any of the designated types of duty.

University: An institution accredited in the current publication of Accredited Institutions of Higher Education.

Usual and Customary (U&C):

1. The Usual fee - the fee most frequently charged or accepted for covered medical care or supplies by a Physician or Hospital; and
2. The Customary fee - the fee charged or accepted for covered medical care or supplies by those of similar professional standing in the same geographical area; "area" means a region large enough to determine a cross section of providers of medical care or supplies.

Utilization Review: Process by which consistent and measurable standards are applied in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity.

Utilization Review Company: A company with which the Plan Administrator may contract to provide consistent and measurable standards in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity. The Utilization Review Company's role is to ensure the best use of health care services, eliminating unnecessary costs while maintaining consideration for the patient's best interests.

Waiting Period: The period of time an Employee must satisfy while working for the Employer before becoming eligible for this Plan. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Well-Baby or Well-Child Care: Medical treatment, services or supplies rendered to a child solely for the purpose of health maintenance and not for the treatment of an illness or injury.