PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

UNION COUNTY GROUP HEALTH INSURANCE PROGRAM FOR RETIREES (RETIRED EMPLOYEE HEALTH BENEFITS PLAN, HEALTH REIMBURSEMENT ACCOUNT AND MAJOR MEDICAL PLAN)

Effective
July 1, 2019

Introduction

This document is a description of Union County's Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan) (the Plan). No oral interpretations, past, present or future can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Union County urges that this document be read carefully. If anything in this document is not clear or questions arise about Plan benefits or Plan claims procedures, the Plan Administrator should be contacted (information located in the General Information section of this document).

Coverage under the Plan will take effect for an eligible Retired Employee and designated Dependents when the Retired Employee and such Dependents satisfy all the eligibility requirements of the Plan. The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Contents

General Plan Information

This Plan is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act.

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Retired Employees. The Plan is not insured.

GROUP NAME: Union County Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan)

PLAN NUMBER: 502

GROUP PLAN NUMBER: 254

TAX ID NUMBER: 56-6000345

PLAN EFFECTIVE DATE: Effective as restated, July 1, 2019

PLAN YEAR: July 1 - June 30

EMPLOYER INFORMATION	Union County 500 North Main Street, Suite 130 Monroe, North Carolina 28112 (704) 283-3869
PLAN ADMINISTRATOR	Union County 500 North Main Street, Suite 130 Monroe, North Carolina 28112
NAMED FIDUCIARY	Union County 500 North Main Street, Suite 130 Monroe, North Carolina 28112
AGENT FOR SERVICE OF LEGAL PROCESS	Union County 500 North Main Street, Suite 130 Monroe, North Carolina 28112
CLAIMS ADMINISTRATOR	Maestro Health P. O. Box 1178 Matthews, NC 28106 (855) 522-1824 mycoverage.maestrohealth.com

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

Eligibility for Participation

ELIGIBILE CLASSES OF RETIRED EMPLOYEES

(1) Any Retired Employee of the Employer or Elected Official who (i) was employed by the Employer before July 1, 2008 and covered under the Plan at the time of retirement, (ii) retired from service (regular or disability) under the provisions of the North Carolina Local Government Retired Employee's Retirement System (NCLGERS) or the North Carolina Law Enforcement Officer's Benefit and Retirement Fund (NCLEOBRF), and (iii) had earned, immediately prior to such retirement, due to continuous full-time employment by the Employer, ten (10) consecutive years of creditable service under either the NCLGERS or the NCLEOBRF without a break in service.

(2) Any Retired Employee of the Employer or Elected Official who (i) was employed by the Employer on or after July 1, 2008 and prior to July 1, 2013 and covered under the Plan at the time of retirement, (ii) retired from service (regular or disability) under the provisions of the North Carolina Local Government Retired Employee's Retirement System (NCLGERS) or the North Carolina Law Enforcement Officer's Benefit and Retirement Fund (NCLEOBRF), and (iii) had earned, immediately prior to such retirement, due to continuous full-time employment by the Employer, twenty (20) consecutive years of creditable service under either the NCLGERS or the NCLEOBRF without a break in service.

Employees of the Employer hired on or after July 1, 2013 shall not be eligible for participation under the Plan.

ELIGIBILITY REQUIREMENTS

An eligible person:

A. Is a Retired Employee of the Employer or covered Elected Official who was employed before July 1, 2008, (i) is less than 65 years of age, (ii) is not eligible for Medicare Part B, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned ten (10) consecutive years of creditable service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

B. Is a Retired Employee of the Employer or covered Elected Official who was employed on or after July 1, 2008 and prior to July 1, 2013, (i) is less than 65 years of age, (ii) is not eligible for Medicare Part B, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned twenty (20) consecutive years of creditable service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

C. Is a former County Manager (Retired Employee) who (i) attained age 60 at the time of separation from service, (ii) was separated from service with the County for a reason other than gross misconduct; (iii) elects to continue coverage prior to separation such that there is no lapse in coverage.

D. Any other eligible class as defined by the Union County Board of County Commissioners

E. A person who holds the office of Union County Sheriff or Register of Deeds at the time of his or her retirement, is covered under the Union County Employee Group Health Plan at the time of his or her retirement and falls within an eligible class of Retired Employees as described above.

F. Must meet all of the eligibility requirements and is a citizen of the United States or is legally permitted to reside in the United States by virtue of possessing a valid green card, H-1B or L-1 visa issued by the United States Citizenship and Immigration Services

G. Must meet all of the eligibility requirements and enroll in the Plan within 31 days of the date he or she becomes first eligible for coverage.

When spouses are both Retired Employees of the Employer, only one person is eligible for coverage under the Plan as the Covered Retired Employee. The Spouse may be covered as a Dependent of the Covered Retired Employee.

The covered Retired Employee must notify Maestro Health he or she has access to health insurance coverage under another Plan, such as Medicare or through coverage provided by the spouse's employer.

In addition to the eligibility requirements set forth in this Plan Document, only Retired Employees who maintain legal residency in the United States can be considered for eligibility as Covered Retired Employees. All other provisions and stipulations of the Plan will apply.

DEPENDENT ELIGIBILITY

A Dependent is any one of the following persons:

A. The spouse of a **covered Retired Employee** and/or children, of a **covered Retired Employee**, from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the last day of the month of the child's birthday.

B. The spouse of a covered retired **elected official holding the Office of Union County Sheriff or Register of Deeds** and children, of a covered retired **elected official holding the Office of Union County Sheriff or Register of Deeds**, from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the last day of the month of the child's birthday.

Dependents of retired employees who are eligible for Medicare Part B are ineligible for dependent overage under Union County's Group Health Insurance Program for Retirees.

Dependents who were (1) enrolled in Medicare Part B prior to October 1, 2018 and (2) covered under the Plan prior to October 1, 2018 may continue coverage under the Plan provided all other eligibility requirements are met.

In addition to the eligibility requirements set forth in this Plan Document, only family members of the Covered Retired Employee who maintain legal residency in the United States can be considered for eligibility as Covered Dependents. All other provisions and stipulations of the Plan will apply.

The Spouse:

A. Is the spouse of a Retired Employee of the Employer or covered Elected Official who was employed before July 1, 2008, (i) is less than 65 years of age, (ii) Is not eligible for Medicare, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned ten (10) consecutive years of creditable service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

B. Is the spouse of a Retired Employee of the Employer or covered Elected Official who was employed on or after July 1, 2008 and prior to July 1, 2013, (i) is less than 65 years of age, (ii) Is not eligible for Medicare, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned twenty (20) consecutive years of creditable

service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

C. If the spouse of an elected official holding the office of Union County Sheriff or Register of Deeds at the time of his or her retirement, covered under the Union County Employee Group Health Plan at the time of his or her retirement and falling within an eligible class of Retired Employees.

H. Is the spouse of a former County Manager (Retired Employee) who (i) attained age 60 at the time of separation from service, (ii) was separated from service with the County for a reason other than gross misconduct; (iii) elects to continue coverage prior to separation such that there is no lapse in coverage.

D. Is the spouse of any other eligible class as defined by the Union County Board of County Commissioners.

The term "Spouse" shall mean the person recognized as the covered member's husband or wife under the laws of the state where the covered member lives. A spouse may be a same-sex spouse possessing a valid marriage license. The Plan Administrator may require documentation proving a legal marital relationship.

Spouses of retired employees who are eligible for health insurance coverage through their current employer are ineligible for coverage under Union County's Group Health Insurance Program for Retirees.

The covered Retired Employee must notify Maestro Health if his or her spouse has access to health insurance coverage under another Plan, such as through coverage provided by the spouse's employer or as a result of a divorce decree. For more information, the Coordination of Benefits section of this document should be consulted.

A Child:

A. Is the child of a Retired Employee of the Employer or covered Elected Official who was employed before July 1, 2008, (i) is less than 65 years of age, (ii) Is not eligible for Medicare, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned ten (10) consecutive years of creditable service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

B. Is the child of a Retired Employee of the Employer or covered Elected Official who was employed on or after July 1, 2008 and prior to July 1, 2013, (i) is less than 65 years of age, (ii) Is not eligible for Medicare, (iii) retired from service (regular or disability) under the provisions of the NCLGERS or NCLEOBRF, (iv) immediately prior to such retirement earned twenty (20) consecutive years of creditable service, and (v) earned such years of creditable service due to continuous full-time employment by the Employer.

C. If the child of an elected official holding the office of Union County Sheriff or Register of Deeds at the time of his or her retirement, covered under the Union County Employee Group Health Plan at the time of his or her retirement and falling within an eligible class of Retired Employees.

I. Is the child of a former County Manager (Retired Employee) who (i) attained age 60 at the time of separation from service, (ii) was separated from service with the County for a reason other than gross misconduct; (iii) elects to continue coverage prior to separation such that there is no lapse in coverage.

D. Is the child of any other eligible class as defined by the Union County Board of County Commissioners.

If both mother and father are Retired Employees or Active Employees, their children will be covered as Dependents of the mother or father, but not of both.

The term "children" shall include natural children, step-children, legally adopted children or children placed with the covered Retired Employee in anticipation of adoption, Foster Children, and children for whom the Retired Employee is the legal guardian. A child may be a dependent regardless of whether such child was born out of wedlock, is not claimed as a dependent on the tax return of the Retired Employee, or does not reside in the

Retired Employee's PPO service area. Step children who reside in the Retired Employee's household may also be included as long as a natural parent remains married to the Retired Employee.

If a covered Retired Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase child "placed with a covered Retired Employee in anticipation of adoption" refers to a child whom the Retired Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The Plan Administrator may require legal documentation of child relationship to Retired Employee.

When the child reaches the limiting age, coverage will end on the last day of the month of the child's birthday.

The covered Retired Employee must notify Maestro Health if his or her Dependent child has access to health insurance coverage under another Plan, such as through coverage provided by the spouse's employer or as a result of a divorce decree. For more information, the Coordination of Benefits section of this document should be consulted.

Disabled Children

A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Retired Employee for support and maintenance and unmarried.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child(ren) reside with the Participant, provided the Child or Child(ren) are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

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

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains all of the following information:

1. The name of an issuing State child support enforcement agency.
2. The name and mailing address (if any) of the Retired Employee who is a Participant under the Plan or eligible for enrollment.
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.

To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth above in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

An NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
    a. Whether the Child is covered under the Plan.
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
    a. Be in writing.
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

These persons are excluded as Dependents:

A. other individuals living in the covered Retired Employee's home, but who are not eligible as defined

B. the legally separated or divorced former Spouse of the Retired Employee;

C. any person who is on active duty in any military service of any country;

D. or any person who is covered under Union County's Group Health Insurance Program for Retired Employees as a Retired Employee or the Union County Employee Group Health Plan as an Active Employee.

If a person covered under the Plan changes status from Retired Employee to Dependent or Dependent to Retired Employee, and the person is covered continuously under the Plan before, during and after the change in status, credit will be given for deductibles (if applicable) and all amounts applied to maximums.

If both parents are Retired Employees, their children will be covered as Dependents of one of the parents, but not of both.

DEPENDENT COVERAGE

A family member of a Retired Employee will become eligible for Dependent coverage on the first day that the Retired Employee is eligible for Retired Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by the Plan.

Enrollment and Effective Date

ENROLLMENT REQUIREMENTS

A Retired Employee must enroll for coverage by filling out and signing an enrollment application. The covered Retired Employee is responsible for completing the Dependent enrollment also, if applicable.

ENROLLMENT REQUIREMENTS FOR NEWBORN CHILDREN

A newborn child of a covered Retired Employee must be enrolled on a timely basis, as defined in the section "Timely Enrollment" following this section. If the child is not enrolled within 31 days of the date of birth, there will be no payment from the Plan and the parents will be responsible for all costs, including nursery care, routine Physician care and Medically Necessary care for covered Illnesses or Injuries, out-of-pocket. If the child is required to be enrolled and is not enrolled within 31 days of birth, the child must wait until the open enrollment period, during which time he/she may be enrolled as a Late Enrollee.

TIMELY OR LATE ENROLLMENT

Timely Enrollment

The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, initially, under a special enrollment period, or due to a family status change. If two Retired Employees (parents of the child(ren) are covered under the Plan and the Retired Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Retired Employee with no waiting period as long as coverage has been continuous.

Late Enrollment

An enrollment is "late" if it is not made on a "timely basis," during a special enrollment period, or within 31 days of a family status change; it is an enrollment that is made during the open enrollment period. Late Enrollees and their Dependents who do not experience a special enrollment event may not join the Plan for coverage for that year. They may only enroll during open enrollment for coverage beginning the next Plan Year.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins at the start of the next Plan Year which is July 1st.

ANNUAL ENROLLMENT PERIOD

The Plan Administrator will declare Annual Enrollment periods at his or her discretion.

Plan Participants will receive detailed information regarding annual enrollment from the Employer, when applicable. During Annual Enrollment periods, covered Retired Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits are right for them.

Benefit choices made during the annual enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

During Annual Enrollment periods, Retired Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices for Late Enrollees made during the annual enrollment period will become effective July 1.

A Plan Participant who fails to make an election during annual enrollment will automatically retain his or her present benefits.

The plan will allow a Retired Employee to make a one-time switch to the Direct Primary Care Option or the Traditional option outside of the normal annual enrollment period. The member must enroll in the same class of coverage he/she is currently enrolled in.

SPECIAL ENROLLMENTS

Special Enrollment Rights

Federal law provides special enrollment provisions under some circumstances. If a Retired Employee is declining enrollment for himself or his Dependents (including his/her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The special enrollment rules are described in more detail below. To request a special enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator c/o Maestro Health, P. O. Box 1178, Matthews, N.C. 28106, (855) 522-1824.

Special Enrollment Periods

Individuals losing other coverage creating a special enrollment right

A Retired Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

A. The Retired Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

B. The coverage of the Retired Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

C. The Retired Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if:

A. The Retired Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e. part-time Employees).

B. The Retired Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

C. The Retired Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

D. The Retired Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

E. If the Retired Employee or Dependent lost other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan), that individual does not have a special enrollment right.

Dependent beneficiaries. If:

A. The Retired Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

B. A person becomes a Dependent of the Retired Employee through marriage, birth, adoption or placement for adoption. If the Retired Employee is not enrolled at the time of the event, the Retired Employee must enroll under this special enrollment period in order for his/her eligible Dependents to enroll under this plan.

C. The Dependent special enrollment period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this special enrollment, the Dependent and/or Retired Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Retired Employee enrolled in the special enrollment period will be effective: in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received; in the case of a Dependent's birth, as of the date of birth; or in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Effective Date

The Enrollment Date for anyone who enrolls under a special enrollment period is the first date of coverage.

You must make written application for special enrollment within **60 days** of the date of loss of eligibility for coverage under:

- Title XIX of the Social Security Act (Medicaid); or
- A State Child Health Plan under Title XXI of the Social Security Act (SCHIP).

Note: You may be eligible for special enrollment if you are eligible for a premium assistance subsidy. You must make written application for special enrollment within 60 days of your eligibility for premium assistance. Please contact the employer for additional information regarding whether a premium assistance subsidy is available to you.

A retired *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *retired employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within the time limits specified above in this section following the date the other health coverage was lost.

You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the *Plan*.

CHANGE IN FAMILY STATUS

The Plan permits a Covered Person to change his/her benefit election during the Plan Year if a qualified change in family status occurs and this change in status affects his/her eligibility to participate in the Plan. Enrollment forms are available from the human resources department. A qualified change in family status may occur for many reasons such as:

A. **Birth or Adoption:** An enrollment form should be completed indicating name of Dependent and date of birth or adoption, along with proof of such.

B. **Marriage:** An enrollment form should be completed indicating name of spouse and date of marriage, along with a copy of the marriage license/certificate.

C. **Divorce or legal separation:** An enrollment form should be completed indicating the date of divorce or separation along with a copy of the divorce decree or legal separation document.

D. **Death**: An enrollment form should be completed indicating the name of the deceased and the date of death.

E. If coverage is to continue for a **Physically/Mentally Challenged Dependent**, then proof of such disability should be submitted.

F. **Termination of employment:** consult TERMINATION OF COVERAGE provisions in this document.

G. **Change of address that results in a service area limitation:** This applies only when a change of address renders Covered Persons ineligible for coverage (e.g., moving outside of an HMO coverage area). To revoke or change enrollment, an enrollment form should be completed indicating new address and new benefit option, if applicable.

H. **Loss of spouse's employment**: consult SPECIAL ENROLLMENT PERIODS provision in this document. If enrolling new Plan members, an enrollment form should be completed.

I. **Judgment, decree or order:** If the Retired Employee or Retired Employee's spouse is subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for the Retired Employee to provide medical coverage for a Dependent child, an enrollment form should be completed adding the Dependent child accordingly.

J. **Medicare or Medicaid:** If a Retired Employee's covered spouse or covered child Dependent loses coverage under Medicare or Medicaid, coverage under this Plan may be obtained by an enrollment application being completed per the Special Enrollment provisions of the Plan. If a Retired Employee or a covered Dependent gains coverage under Medicare or Medicaid, elections under this Plan may be revoked by completing a termination of coverage form (the Covered Person should refer to the Coordination of Benefits section for further information regarding dual coverage rules).

K. **Eligibility for COBRA:** If the Retired Employee, Retired Employee's spouse or Dependent becomes eligible for and elects COBRA under the Plan, the Retired Employee may make a corresponding election to pay for the continuation coverage on a pre-tax basis.

L. **Significant Cost Increases:** If the cost of benefits significantly increases during a Plan Year, as determined by the Employer, the Retired Employee may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the Employer.

M. **Coverage Changes**: If coverage under a benefit option is significantly curtailed during a Plan Year, as determined by the Employer, the Retired Employee may revoke his or her election or elect coverage under another benefit option that offers similar coverage. If the Employer adds a new benefit option during a Plan Year, the Retired Employee may elect the new benefit option.

N. **Changes Under Another Employer's Plan**: The Retired Employee may also change his or her elections to correspond to certain changes that the Retired Employee's spouse or Dependent makes to his or her benefit elections under a benefit plan offered by his or her employer. These rights are subject to conditions or restrictions that may be imposed by the employer or any insurance company providing benefits under the plan.

The Retired Employee must notify the Plan Administrator, in writing, within 31 days of a change in status and comply with all other Plan provisions and requirements. Modified elections are generally effective the 1st of the month following receipt and approval of the Plan Administrator (with the exception of the birth of a newborn, adoption or placement for adoption of a dependent child whose elections will become effective retroactive to the event date).

EFFECTIVE DATE OF RETIRED EMPLOYEE COVERAGE

A Retired Employee will be covered under this Plan as of the first day of the calendar month (first full month) following the date that the Retired Employee satisfies all of the following:

A. The eligibility requirement;

B. The Retired Employee requirement; and

C. The enrollment requirements of the Plan.

Retired Employee Requirement: A Retired Employee must be a former Active Employee (as defined by this Plan) for this coverage to take effect.

EFFECTIVE DATE OF DEPENDENT COVERAGE

A Dependent's coverage will take effect on the day that the eligibility requirements are met; the Retired Employee is covered under the Plan; and all enrollment requirements are met.

PLAN BENEFITS

Schedule of Benefits

In order for Covered Persons to utilize benefits for which they are eligible and in the most cost-effective way, the appropriate party as indicated below should be contacted for verification of eligibility, network providers and specific benefits.

Verification of Eligibility for Medical and Dental Benefits:

Maestro Health, (855) 522-1824

This number should be contacted to verify eligibility for Plan benefits before the charge is incurred.

PLAN OPTION

Two options are available to plan members: The Traditional Option and The Direct Primary Care Option.

PLAN LIMITATIONS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these and other capitalized terms are in the Defined Terms section of this document.

This document contains a detailed schedule of coverage available to any Plan Participant, at no cost. If more information is needed, Covered Persons should contact Maestro Heath.

Note: The following services must be pre-certified by calling 1-855-522-1824 or 704-815-3961 or reimbursement from the Plan may be reduced.

- **A.** Inpatient Hospitalizations
- **B.** Bletharoplasty / Ptosis repair
- **C.** Botox Injections
- **D.** Breast Reduction Surgery
- **E.** Dialysis
- **F.** DME over $1,000
- **G.** Home Health Care
- **H.** Home Infusion Therapy
- **I.** Hysterectomy
- **J.** Laminectomy*Discectomy*Spinal Fusion*Vertabroplasty
- **K.** Mastectomy or oophorectomy, prophylactic, risk reduction
- **L.** Panniculectomy (removal of excess skin)
- **M.** PET scans (position emission tomography)

N. Prosthetic Appliances (over $1,000) including Cochlear Implants

O. Private Duty Nursing

P. Skilled Nursing facility

Q. Synvisc/ Supartz Inj. (for osteoarthritis of the knee)

R. Transplants

S. Treatment of OSA (Surgery, CPAP or BIPAP, not to include sleep studies)

T. UPPP or Somnoplasty (uvulopalatopharyngolasty)

U. Varicose Vein Surgery

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

IMPORTANT

The Cost Management section of this document should be consulted for contact information and specific requirements for pre-certification and other important medical management provisions that may impact the benefits received.

NETWORK PROVIDERS

This Plan has chosen to offer several networks that are intended to be convenient to Covered Persons' geographic locations. The appropriate network should be contacted in order to verify a provider or facility is in the given network, etc.

Health Care Provider Network	Out of Area Health Care Provider Network
MedCost 800-824-7406 www.medcost.com	PHCS Health Directions 800-678-7427 www.multiplan.com
Paladina Health 866-808-6005 www.paladinahealth.com ***This Network provider is for members enrolled in the Direct Primary Care Option only.	

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

All Covered Charges for non-participating providers are subject to the Usual and Reasonable fee regardless of percentage level payable. All services for which Maestro Health has contracted a negotiated rate will be paid at the Network level of benefits.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

- **A.** If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the Network service area.
- **B.** If a Covered Person is out of the Network service area and has a Medical Emergency requiring immediate care.
- **C.** If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.
- **D.** If there are no Network Providers within a 50-mile radius of where the Covered Person resides.
- **E.** If a Covered Dependent, under a qualified medical support court order, resides outside of the Network area.

Since the Health Reimbursement Accounts (Traditional Option) pay benefits at 100% of the Usual and Reasonable Charge, use of Network Providers will not increase the percentage paid under that part of the Plan.

DEDUCTIBLES/CO-PAYMENTS

Deductibles/Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Benefit Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each July 1st, a new deductible amount is required. Deductibles will accrue toward the 100% maximum out-of-pocket payment. Expenses applied toward the network deductible will not accrue toward the non-network deductible and vice versa.

A co-payment is a smaller amount of money that is paid each time a Prescription Drug is filled. Co-payments will accrue toward the 100% maximum out-of-pocket payment.

COINSURANCE AND OUT-OF-POCKET LIMITS

Covered Major Medical Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Expenses applied toward the network out-of-pocket do not accrue toward the non-network out-of-pocket and vice versa. Expenses applied toward the prescription plan out-of-pocket do not accrue toward the network or non-network out-of-pockets and vice versa. Then, Covered Charges of the Major Medical Benefits will be payable at 100% except for the charges excluded for the rest of the Plan Year.

Table 1: Schedule of Benefits – Health Plan
Traditional and Direct Primary Care Plan Options

PREVENTIVE CARE Includes, but is not limited to, office visits, pap smears, mammograms, prostate screenings, cancer screenings, gynecological exams, routine physicals, well child care, immunizations and flu shots	100% coverage per Covered Person
VISION CARE Includes routine eye examination, frames, lenses and contact lenses	100% coverage up to $150 per Plan Year per Covered Person (This is first dollar coverage. Remaining charges are not subject to HRA or Medical Plan reimbursement)
PRESCRIPTION DRUGS	Retail - 30-day supply Generic drug: 0% coinsurance Preferred Brand Drug: 20% coinsurance - minimum of $20. Non-Preferred Brand Drug: 40% coinsurance - minimum of $40 Specialty Drug: 40% coinsurance – max of $150 Mail Order - 90-day supply Generic drug: 0% coinsurance Preferred Brand drug: 20% coinsurance – minimum of $60 Non-Preferred Brand drug: 40% coinsurance - minimum of $120 Specialty Drug: 40% coinsurance – max of $450

Table 2: Health Reimbursement Account
Annual Allocation and Maximum

Traditional Option:

Routine Medical Deductible Per Plan	$150
ANNUAL HRA ALLOCATION MADE BY EMPLOYER	
Retiree Only Coverage	$ 750
Retiree Plus Spouse Coverage	$ 1,250
Retiree Plus Child(ren) Coverage	$ 1,500
Retiree Plus Family Coverage	$ 1,875
MAXIMUM HRA ACCUMULATION	
Retiree Only Coverage	$ 2,000
Retiree Plus Spouse Coverage	$ 3,300
Retiree Plus Child (ren) Coverage	$ 4,000
Retiree Plus Family Coverage	$ 5,000

Direct Primary Care Option

Routine Medical Deductible Per Plan	$ 0
ANNUAL HRA ALLOCATION MADE BY EMPLOYER	
This plan does not offer an HRA benefit.	$ 0

Table 3A: Major Medical Plan Deductibles and Coinsurance

Traditional Option:

	MAJOR MEDICAL DEDUCTIBLE	
	IN-NETWORK	OUT OF NETWORK
Retiree Only Coverage	$600	$600
Retiree Plus Spouse Coverage	$1,000	$1,000
Retiree Plus Child(ren) Coverage	$1,250	$1,250
Retiree Plus Family Coverage	$1,500	$1,500
	COINSURANCE MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
	IN NETWORK	OUT OF NETWORK
Retiree Only Coverage	$2,600	$4,600
Retiree Plus Spouse Coverage	$4,300	$7,700
Retiree Plus Child(ren) Coverage	$5,250	$9,250
Retiree Plus Family Coverage	$6,500	$11,500
	PRESCRIPTION COINSURANCE MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
	PER PARTICIPANT	FAMILY MAXIMUM
Retiree Only Coverage	$1,000	
Retiree Plus Spouse Coverage	$1,000	$2,000
Retiree Plus Child(ren) Coverage	$1,000	$3,000
Retiree Plus Family Coverage	$1,000	$4,000

Table 3B: Major Medical Plan Deductibles and Coinsurance

Direct Primary Care Option:

	MAJOR MEDICAL DEDUCTIBLE	
	IN-NETWORK	OUT OF NETWORK
Retiree Only Coverage	$0	$0
Retiree Plus Spouse Coverage	$0	$0
Retiree Plus Child(ren) Coverage	$0	$0
Retiree Plus Family Coverage	$0	$0
	COINSURANCE MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
	IN NETWORK	OUT OF NETWORK
Retiree Only Coverage	$2,000	$4,000
Retiree Plus Spouse Coverage	$3,300	$6,700
Retiree Plus Child(ren) Coverage	$4,000	$8,000
Retiree Plus Family Coverage	$5,000	$10,000
	PRESCRIPTION COINSURANCE MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	
	PER PARTICIPANT	FAMILY MAXIMUM
Retiree Only Coverage	$1,000	
Retiree Plus Spouse Coverage	$1,000	$2,000
Retiree Plus Child(ren) Coverage	$1,000	$3,000
Retiree Plus Family Coverage	$1,000	$4,000

Table 4A: Schedule of Medical Benefit Covered Charges for Health Reimbursement Account and Major Medical Plan Traditional Plan Option

	Health Reimbursement Account	Major Medical Benefits	
		Network Providers	Non-Network Providers
Hospital Services			
Room and Board If a facility has only private rooms, the Plan will consider the average private room rate.	100% of the Hospital's semiprivate room rate	80% of the Hospital's semiprivate room rate	60% of the Hospital's semiprivate room rate
Intensive Care Unit	100% of the Hospital's ICU rate	80% of the Hospital's ICU rate	60% of the Hospital's ICU rate
All Other Hospital Charges	100%	80%	60%
Preadmission Testing	100%	80%	60%
Emergency Room	100%	80%	80%
Skilled Nursing Facility If a facility has only private rooms, the Plan will consider the average private room rate.	100% of the facility's semiprivate room rate	80% facility's semiprivate room rate	60% of the facility's semiprivate room rate
A combined 60 days per Plan Year limit applies to all Skilled Nursing Facility confinements in Network and Non-Network facilities under the Health Reimbursement Account and Major Medical Benefits.			
Physician Services			
For Plan purposes, a Primary Care Physician is a family practitioner, a general internist, a pediatrician and an OB/GYN. ****Members enrolled in the **Direct Primary Care Option** must utilize the Paladina Health providers and service will be at 100% and not covered under this plan.**** (Members will have access to OB/GYN, Pediatric and Mental Nervous provider services outside the Paladina Health office and those services will be covered at 80% if in network and at 60% if out of network.)			
Inpatient visits	100%	80%	60%
Office visits	100%	80%	60%
Surgery	100%	80%	60%

	Health Reimbursement Account	Major Medical Benefits	
		Network Providers	Non-Network Providers
Allergy testing	100%	80%	60%
Allergy serum and injections	100%	80%	60%
Chemotherapy, radiation therapy or Infusion therapy	100%	80%	60%
Clinical Trial Expenses	100%	80%	60%
Colonoscopy(age 50 and above) includes associated services that day -One per year- (routine or diagnostic)	100%	100% Subsequent treatment subject to Deductible and Coinsurance	60%
Colonoscopy(under age 50) includes associated services that day	100%	80%	60%
Diagnostic Laboratory and X-ray Services	100%	80%	60%
Dialysis	100%	80%	
Home Health Care	100%	80%	60%
A combined 60 days per Plan Year limit applies to all Home Health Care using Network and Non-Network providers under the Health Reimbursement Account and Major Medical Benefits.			
Inpatient Prescription Drugs	100%	80%	60%
Hospice Care	100%	80%	60%
Bereavement Counseling	100%	80%	60%
Ambulance Service	100%	80%	80%
Jaw Joint/TMJ	100%	80%	60%
Hair Piece After Chemotherapy, Radiation Therapy or Burn treatment.	100%	80%	60%
A combined limit of one wig lifetime applies to Network and Non-Network providers under the Health Reimbursement Account and Major Medical Benefits.			
Prosthetic Bras (4) after Mastectomy	100%	80%	60%

	Health Reimbursement Account	Major Medical Benefits	
		Network Providers	Non-Network Providers
Occupational Therapy	100%	80%	60%
Speech Therapy	100%	80%	60%
Physical Therapy	100%	80%	60%
Durable Medical Equipment	100%	80%	60%
Prosthetics	100%	80%	60%
Organ Transplants	100%	80%	60%
Pregnancy	100%	80%	60%
Other Covered Expenses	100%	80%	60%
Smoking/Tobacco Cessation	100%	100%	60%
Mental Disorders			
Inpatient/Partial Hospitalization	100%	80%	60%
Outpatient Care	100%	80%	60%
Substance Abuse			
Inpatient/Partial Hospitalization	100%	80%	60%
Outpatient Care	100%	80%	60%

Table 4B: Schedule of Medical Benefit Covered Charges for
Major Medical Plan
Direct Primary Care Plan Option

	Major Medical Benefits	
	Network Providers	**Non-Network Providers**
Hospital Services		
Room and Board If a facility has only private rooms, the Plan will consider the average private room rate.	80% of the Hospital's semiprivate room rate	60% of the Hospital's semiprivate room rate
Intensive Care Unit	80% of the Hospital's ICU rate	60% of the Hospital's ICU rate
All Other Hospital Charges	80%	60%
Preadmission Testing	80%	60%
Emergency Room	80%	80%
Skilled Nursing Facility If a facility has only private rooms, the Plan will consider the average private room rate.	80% facility's semiprivate room rate	60% of the facility's semiprivate room rate
A combined 60 days per Plan Year limit applies to all Skilled Nursing Facility confinements in Network and Non-Network facilities under the Health Reimbursement Account and Major Medical Benefits.		
Physician Services		
For Plan purposes, a Primary Care Physician is a family practitioner, a general internist, a pediatrician and an OB/GYN. ****Members enrolled in the **Direct Primary Care Option** must utilize the Paladina Health providers and service will be at 100% and not covered under this plan.**** (Members will have access to OB/GYN, Pediatric and Mental Nervous provider services outside the Paladina Health office and those services will be covered at 80% if in network and at 60% if out of network.)		
Inpatient visits	80%	60%
Office visits	80%	60%
Surgery	80%	60%

	Major Medical Benefits	
	Network Providers	**Non-Network Providers**
Allergy testing	80%	60%
Allergy serum and injections	80%	60%
Chemotherapy, radiation therapy or Infusion therapy	80%	60%
Clinical Trial Expenses	80%	60%
Colonoscopy(age 50 and above) includes associated services that day -One per year- (routine or diagnostic)	100% Subsequent treatment subject to Deductible and Coinsurance	60%
Colonoscopy(under age 50) includes associated services that day	80%	60%
Diagnostic Laboratory and X-ray Services	80%	60%
Dialysis	80%	
Home Health Care	80%	60%
A combined 60 days per Plan Year limit applies to all Home Health Care using Network and Non-Network providers under the Major Medical Benefit.		
Inpatient Prescription Drugs	80%	60%
Hospice Care	80%	60%
Bereavement Counseling	80%	60%
Ambulance Service	80%	80%
Jaw Joint/TMJ	80%	60%
Hair Piece After Chemotherapy, Radiation Therapy or Burn treatment.	80%	60%
A combined limit of one wig lifetime applies to Network and Non-Network providers under the Major Medical Benefit.		
Prosthetic Bras (4) after Mastectomy	80%	60%

	Major Medical Benefits	
	Network Providers	**Non-Network Providers**
Occupational Therapy	80%	60%
Speech Therapy	80%	60%
Physical Therapy	80%	60%
Durable Medical Equipment	80%	60%
Prosthetics	80%	60%
Organ Transplants	80%	60%
Pregnancy	80%	60%
Other Covered Expenses	80%	60%
Smoking/Tobacco Cessation	100%	60%
Mental Disorders		
Inpatient/Partial Hospitalization	80%	60%
Outpatient Care	80%	60%
Substance Abuse		
Inpatient/Partial Hospitalization	80%	60%
Outpatient Care	80%	60%

Table 5: Dental Plan Schedule of Benefits

Dental Deductible Amount per Plan Year

Individual Deductible……..	$50
Maximum Family Deductible……	3 individuals

The Deductible does not apply to Class I Preventive Services.

Dental Percentage Payable

Class I Preventive Services……..	100%
Class II Basic Services……..	80%
Class III Major Services……..	50%

Maximum Benefit Amounts

Calendar Year Maximum ……..	$1,000
Lifetime Maximum for Temporomandibular Joint Dysfunction (TMJ) Treatment……..	$1,000

Plan Year is defined as the period July 1 through June 30.

Medical Benefits

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

Deductibles – Health Reimbursement Account and Major Medical Plan (Traditional Option)

The Health Reimbursement Account and the Major Medical Plan are subject to deductibles.

The Routine Medical Deductible is a dollar amount paid for Covered Services provided to one or more Covered Persons that must be paid by the Covered Employee before benefits of the Health Reimbursement Account are payable. New Deductibles apply each July 1st.

When the Routine Medical Deductible is satisfied, Covered Charges are next payable under the Health Reimbursement Account. After Union County's Annual Allocation and any Accumulation to the Health Reimbursement Account for the Plan Year is exhausted, the Major Medical Deductible applies.

The Major Medical Deductible is a dollar amount paid for Covered Services provided to one or more Covered Persons that must be paid by the Covered Person before benefits of the Major Medical Plan are payable. New Deductibles apply each July 1st.

Benefit Description – Health Reimbursement Account (Traditional Option)

The Plan will provide the Health Reimbursement Accounts Benefits stated below.

On July 1st of each year, Union County makes an Annual Allocation. The amount of the Annual Allocation is shown in the Schedule of Benefits.

After satisfaction of the Routine Medical Deductible shown in the Schedule of Benefits the Annual Allocation is available throughout the Plan Year to pay Covered Services. Covered Services are outlined in the in the Schedule of Benefits.

At the end of each Plan Year, an amount equal to 50% of any unused Annual Allocation(s) will roll over and be available in the following Plan Year. The sum of the Annual Allocation for the then-current Plan Year plus the sum of any amounts rolled over from prior years will not exceed the Maximum Accumulation shown in the Schedule of Benefits.

Total charges submitted that exceed the Health Reimbursement Account Annual Allocation and any Accumulation shall be subject to the Major Medical Deductible and then to the Covered Person's coinsurance amount of the Major Medical Benefits.

The Plan will pay the Medical Benefits stated below.

Medical Benefits apply when a Covered Person incurs Covered Charges for Covered Services for care of an Injury, Sickness or pregnancy and while the Plan covers the person.

Benefit Payment

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments (if applicable). Payment will be made at the rate shown as noted in the Schedule of Benefits.

Out-of-Pocket Limit

Covered Charges are payable at the percentages shown each Benefit Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

Finally, the following will never accumulate toward the out-of-pocket limit:

A. Cost containment penalties

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is considered to be incurred on the date that the service or supply is performed or furnished.

A. ***Hospital Care.*** *The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center.*

a. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

b. Room charges made by a Hospital having only private rooms will be considered at the average private room rate as directed by Medicare's UB92 or UB04 guidelines.

c. Charges for an Intensive Care Unit stay are considered as described in the Schedule of Benefits.

B. ***Coverage of Pregnancy.*** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. Dependent children are not eligible for coverage for any expenses in connection with pregnancy; however, certain services that are included under Preventive Care may be eligible for coverage.

C. ***Skilled Nursing Facility Care***

a. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

i. the patient is confined as a bed patient in the facility;

ii. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

iii. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

b. Covered charges for a Covered Person's care in these facilities are limited as shown in the Schedule of Benefits.

D. ***Physician Care.*** *The professional services of a Physician for surgical or medical services.*

a. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

b. CRNA charges, when billed in addition to the anesthesiologist's charges, will not exceed 50% of the anesthesiologist's Usual and Reasonable allowance or the contracted network allowance.

c. Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

i. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

ii. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure.

E. ***Home Health Care Services and Supplies.*** *Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.*

a. Benefit payment for nursing, home health aide and therapy services.

b. A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

F. ***Hospice Care Services and Supplies***. Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

a. Covered charges for Hospice Care Services and Supplies.

i. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered spouse and/or covered Dependent children). Bereavement services must be furnished within six months after the patient's death.

G. ***Other Medical Services and Supplies.*** These services and supplies not otherwise included in the items above are covered as follows:

a. ***Local Medically Necessary professional land or air ambulance service***. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

b. ***Anesthetic;*** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

c. ***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 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

d. ***Radiation or chemotherapy and treatment with radioactive substances.*** The materials and services of technicians are included.

e. ***Clinical Trial Expenses*** when the following conditions and procedures are met:

i. You provide Union County with:

1. A copy of the clinical trial treatment protocol from the facility that conducted or will conduct the clinical trial; and
2. A copy of the Covered Person's signed consent and authorization to participate in the clinical trial; and
3. You provide documentation that demonstrates to the satisfaction of Union County that:
    a. The treatment was provided as part of an ongoing Phase II or III clinical trial sponsored by the National Cancer Institute, National Institute of Health or the FDA; and
    b. The treatment provided by the clinical trial is covered by Your Plan; and
    c. Funding is not available for the routine costs of the clinical trial from the National Cancer Institute, the National Institute of Health, the FDA or any other entity. "Routine costs" shall have the meaning attributed to it by the Centers for Medicare and Medicaid Services in its Coverage Issues Manual for clinical trials; and
    d. The clinical trial has been approved by an institutional review board. An "institutional review board" shall mean a committee of physicians, statistics, researchers, community advocates and others that ensures that a clinical trial is ethical and that the rights of trial participants are protected; and

Approved Clinical Trials in accordance with PHSA Section 2709. An "Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-threatening Condition and is described in any of the following subparagraphs:

1. Federally funded trials for studies or investigations which are approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in bullets 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

h. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

2. A “Life-threatening Condition”, for purposes of this benefit, means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

3. Benefits are available for a "Qualified Individual" who is a covered person eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another Life-threatening condition, and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the covered person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

4. Coverage is provided only for “Routine Patient Costs” which includes all items and services consistent with the coverage provided in the Plan that is typically covered for a covered person who is not enrolled in a clinical trial. Routine Patient Costs do not include the cost of:

5. The investigational item, device, or service, itself;
6. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
7. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

8. Benefits for Routine Patient Costs that meet the conditions set forth above will be determined based upon the provider and type of service in accordance with the Schedule of Medical Benefits.

f. ***Initial contact lenses or glasses required following cataract surgery.***

g. ***Dialysis.***

a. All renal dialysis services and supplies will be paid at the Reasonable and Appropriate Amount, whether the treating provider is a Network Provider or a Non-Network Provider. This Plan accesses no network for any renal dialysis claims.

b. If you or your covered dependent has End-Stage Renal Disease (“ESRD”), the Plan’s medical program’s primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer statute requires the Plan to identify members of the Plan, including eligible dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

c. **Assignment of Benefits**

- You may assign benefits for medical expenses covered under this Plan to a provider as consideration in full for services rendered; however, whether such benefits are paid directly to you or to the provider, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such Assignment of Benefits is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment has been received before the proof of loss is submitted.
- You may not, at any time either during the time in which you are a participant in the Plan or following your coverage termination, assign your right to sue to recover benefits under the Plan, to enforce rights due under the Plan, or to any other causes of action which you may have against the Plan or its fiduciaries.
- A provider which accepts an Assignment of Benefits does so in accordance with this Plan and does so as consideration in full for services rendered. Any such provider is bound by the rules and provisions set forth within the terms of this document.

d. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.

e. **Reasonable and Appropriate Amount** refers to covered charges as identified by the Plan Administrator, taking into consideration any of a number of factors, including: the fees which the Provider most frequently charges the majority of patients for the service or supply, the amount the Provider accepts from others as payment for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same area by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates.

At the Plan Administrator's sole discretion, to be Reasonable and Appropriate, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures, and generally will not exceed 125% of the current Medicare allowable fee for the appropriate area, applicable to the treatment, supplies, and/or services. In the event the Provider utilizes procedure codes that do not have an associated Medicare allowable fee (also known as unlisted procedure codes), Plan Administrator has the sole discretion to determine the most appropriate procedure code for the services rendered with an associated fee. Provider must provide necessary documentation, upon request, to allow Plan Administrator to perform these functions.

The term "area" is defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made.

The term "Reasonable and Appropriate" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Reasonable and Appropriate charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Reasonable and Appropriate.

Reasonable and Appropriate charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP), manufacturer's retail pricing (MRP), or Medicare equivalency rates.

Charges for services, supplies, and/or treatments meant to treat or correct a condition which arises solely due to a Provider's error are not considered to be Reasonable and Appropriate.

f. Assignment of Benefits means an arrangement whereby the covered individual assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, to a provider. If a provider accepts said arrangement, the provider' rights to receive Plan benefits are equal to those of the covered individual, and are limited by the terms of this Plan. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits as consideration in full for services, supplies, and treatment rendered.

g. Maximum Allowable Amount is the dollar amount of benefits payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Amount may be the lesser of:

- The Reasonable and Appropriate Amount (for Non-Network Providers);
- The allowable charge otherwise specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a health care provider; or
- The actual billed charges for the covered services.

The Plan has the discretionary authority to determine the Maximum Allowable Amount and if a service is otherwise covered under all other provisions of the Plan.

The Maximum Allowable Amount will not include any identifiable billing mistakes including, but not limited to, up-coding, unbundled charges, duplicate charges, and charges for services not performed.

h. ***Rental of durable medical or surgical/medical equipment and medical supplies,*** including enteral formula/supplies when determined to be the sole source of nutrition, if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase but only when agreed to by the Plan Administrator. An oxygen concentrator deemed to be Medically Necessary, however, will be limited to rental only.

i. ***Laboratory studies.***

j. ***Mental Health and Substance Abuse Treatment.*** Covered charges for care, supplies and treatment of

k. ***Mental Disorders and Substance Abuse*** will be limited as follows:

i. *Physician's visits*

ii. MD, Psychologist (Licensed Psychologist or Licensed Psychological Associate), Licensed Clinical Social Worker (CSW), Master of Social Work (MSW), Licensed Professional Counselor (LPC), may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

l. ***Injury to or care of mouth, teeth and gums*****.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

m. ***Excision of tumors*** and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

n. ***Emergency repair due to*** **Injury** to sound natural teeth. This repair must be made with 12 months from the date of an accident.

o. ***Surgery needed to correct accidental*** **injuries** to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

p. ***Excision of benign bony growths*** of the jaw and hard palate.

q. ***External incision and drainage of cellulitis.***

r. ***Incision of sensory sinuses,*** salivary glands or ducts.

   i. No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, removal of impacted teeth, and preparing the mouth for the fitting of or continued use of dentures.

s. ***Occupational therapy*** by a licensed occupational therapist, limited as shown in the Schedule of Benefits. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

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

   i. Solid Organs

      1. Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This Plan excludes transplantation of non-human organs.

   ii. Bone Marrow Transplants

      1. Benefits are provided for medically necessary bone marrow transplantation procedures, including, but not limited to, synergic and allogeneic/homologous bone marrow transplantation, as well as, autologous bone marrow transplantation procedures.

   iii. Tissue Replacement

      1. Benefits are provided for the replacement of human tissue (with human tissue or prosthetic devices).

   iv. The following expenses provided they are payable under the provisions of the Plan, will be considered eligible expenses:

      1. Organ acquisition costs including surgical, storage and transportation cost occurred and directly related to the acquisition of an organ used in a covered organ transplant. The maximum eligible expense is limited to $20,000.

      2. Expenses incurred by the recipient:

         a. All physician's, hospital's and other health provider's cost incurred by the recipient and directly related to the covered organ transplant.

         b. Physical therapy, prescription drugs, immunosuppressant drugs, coordinated home care, purchase or rental of medical appliance, oxygen and equipment directly related to the covered organ transplant.

c. Associated travel expenses. If the Covered Person lives more than one hundred miles from the Designated Transplant Facility, the Plan will cover associated travel expenses, including commercial transportation for the Covered Person and one companion and reasonable expenses for lodging and meals for the Covered Person and companion. Reasonable expenses for meals and lodging for the Covered Person and one companion are limited to $250 per day. Transportation, lodging and meal costs are limited to an aggregate maximum of $5,000 per transplant episode for the Covered Person and one companion.

v. Defining Acquisition:

1. Organ/tissue acquisition, including donor expenses not eligible under the donor's plan of benefits, which consist of:

    a. Organ procurement from a non-living donor including removing, preserving and harvesting the organ.

    b. Organ procurement from a living donor including screening the potential donor, transporting the donor to and from the site of the transplant, as well as the medical expenses associated with removal of the donated organ, medical services provided to the donor in the interim, and for follow-up care.

    c. If the transplant procedure is a bone marrow transplant, expenses including the cost involved in the removal of the participant's bone marrow (autologous) or donated marrow (allogeneic). Additional expenses covered:

        i. Expenses for search to identify an unrelated match, and treatment and storage costs of the marrow, up to the time of reinfusion.

        ii. The harvesting of the marrow

vi. Special Rules for Organ Transplants:

1. If requested by the Claims Administrator, a second opinion in writing by a board-certified specialist involved in the field of procedure will be required. The specialist may be required to certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the Covered Person's condition.

2. Charges for obtaining donor organs or tissues are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

    a. evaluating the organ or tissue;

    b. removing the organ or tissue from the donor; and

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

u. The initial purchase, **fitting and repair of custom made or prefabricated orthotics** that are fitted and adjusted such as braces, splints or other appliances which are required for support for an

injured or deformed part of the body as a result of a disabling congenital condition or an injury or sickness. Orthopedic shoes are not covered unless attached to a brace.

v. **Physical therapy** by a licensed physical therapist, an M.D., or a D.O., as shown in the Schedule of Benefits. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

w. **Prescription Drugs** (as defined).

x. **Routine Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

   i. Benefits are provided for preventive and routine care for covered persons in accordance with the regulations under PHS Act Section 2713, "Coverage of Preventive Health Services" (the "recommended preventive services"). The guidelines for these recommended preventive services are established by:

      1. The U.S. Preventive Services Task Force for Grade A and Grade B preventive services;

      2. The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Director of the Centers for Disease Control and Prevention; and

      3. Comprehensive Guidelines supported by the Health Resources and Services Administration (HRSA).

   ii. Coverage of recommended preventive services may be limited to covered persons of a certain age, or may be limited to a certain frequency. Under the guidelines provided by the resources listed above, the specific services included, the age limits and/or the frequency limits may change from time to time. You may also find additional information regarding covered recommended preventive services at:

   https://www.healthcare.gov/coverage/preventive-care-benefits/ **Important Note:** The preventive care services identified through this link are recommended services, not mandated services. It is up to the provider and/or physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered. Preventive care services will be covered at 100% for non-network providers if there is not network provider who can provide a required preventive service.

   iii. If a guideline for a recommended preventive service does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will rely upon reasonable medical management techniques to determine any coverage limitations.

y. **Charges for Routine Well Adult Care**. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

z. **Charges for Routine Well Child Care**. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

aa. **Women's Preventive Services**. With Administration (HRSA) not otherwise addressed by the recommendations of the United States Preventive Service Task Force (USPSTF), which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits.
2. Gestational diabetes screening.
3. Human papillomavirus (HPV) Deoxyribonucleic Acid (DNA) testing.
4. Sexually transmitted infection counseling.
5. Human Immunodeficiency Virus (HIV) screening and counseling.
6. Food and Drug Administration (FDA)-approved contraception methods and contraceptive counseling.
7. Breastfeeding support, supplies and counseling.
8. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/coverage/preventive-care-benefits/.

bb. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts or the replacement of prosthetic devices when there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

cc. **Reconstructive Surgery**. Correction of abnormal congenital conditions, accidental injuries and reconstructive mammoplasties will be considered Covered Charges.

i. This mammoplasty coverage will include reimbursement for:

1. reconstruction of the breast on which a mastectomy has been performed,
2. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
3. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

dd. **Smoking/Tobacco Cessation.** Care or treatment for **Smoking/Tobacco Cessation** programs, limited as outlined on the Schedule of Medical Benefits.

ee. **Speech therapy** by a Physician or qualified speech therapist, when needed due to a Sickness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of a Sickness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

ff. **Sterilization procedures.**

gg. **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

hh. **Coverage of Well Newborn Nursery/Physician Care**.

ii. **Charges for Routine Nursery Care**. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

i. This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2)

enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

ii. The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

iii. Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

v. Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

vi. Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

jj. Charges associated with the initial purchase of a **wig after chemotherapy** as shown in the Schedule of Benefits.

kk. **Diagnostic x-rays.**

ll. **Mastectomy or oophorectomy, prophylactic, risk reduction**. With prior approval by the Plan, based on review for medical necessity, coverage will be provided for a prophylactic, risk reduction mastectomy or oophorectomy for certain covered persons with an established diagnosis or high-risk family history of breast or ovarian cancer. Candidates for such a procedure must submit the physician's recommendation of medical necessity and a treatment plan from the attending physician, along with pertinent medical records, to Maestro Health in order for the Plan to determine the coverage, if any that is available under the Plan. Procedures that are considered urgent or emergency care will be reviewed retrospectively for medical necessity. Benefits payable for approved procedures will be determined in accordance with the "Schedule of Medical Benefits" based upon the provider and type of service.

Medical Plan Exclusions

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan. Generally, exclusions related to Dental Benefits are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

A. **Abortion.** For an elective or non-therapeutic abortion. Except when the life of the mother is endangered by the continued pregnancy, the pregnancy is the result of rape or incest, or the fetus is diagnosed as "incompatible with life".

B. **Acupuncture/acupressure**.

C. **Chiropractic Care.**

D. **Civil insurrection or riot.** Treatment for injuries incurred or exacerbated while participating in a civil insurrection or riot.

E. **Complications of non-covered treatments**. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

F. **Cosmetic surgery**. For cosmetic surgery or procedures, or aesthetic services (including complications arising therefrom).

a. This exclusion does not apply to procedures required as a result of a birth defect, an injury, or if approved as medically necessary for a covered illness.

b. This exclusion does not apply to reconstruction of a breast following a mastectomy, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a mastectomy, including lymphademas, in a manner determined in consultation with the attending physician and the covered person.

G. **Custodial care**. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

H. **Drug Dependency Maintenance Therapy**. Non-abstinence based substance abuse treatment maintenance therapy, such as, but not limited to, methadone, suboxone or subutex maintenance therapies are not covered. Substance abuse treatment may be a covered expense under this Plan. The Schedule of Benefits should be referenced for coverage details.

I. **Educational or vocational testing**. Services for educational or vocational testing or training. This does not apply to diabetic self-management education programs.

J. **Excess charges**. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

K. **Exercise programs**. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

L. **Experimental or not Medically Necessary**. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

a. Coverage may be provided for certain routine patient costs as described in the section "Medical Benefits" for Approved Clinical Trials.

M. **Eye care**. Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye exams, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not

apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult care section of this Plan.

N. **Food supplements.** Related to food supplements or augmentation in any form unless medically necessary to sustain life in a critically ill person.

O. **Foot care**. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). If foot care services are deemed to be Medically Necessary, this Plan will cover such services.

P. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Q. **Forms.** For the completion of medical reports, claim forms or itemized billings.

R. **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

S. **Hair loss.** Care and treatment for hair loss **including** wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

T. **Hearing aids and exams**. Charges for services or supplies in connection with hearing aids or exams for their fitting.

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

V. **Illegal acts**. Charges for services received as a result of Injury or Sickness occurring directly or indirectly as a result of a Serious Illegal Act, a riot or public disturbance, attempting to commit any crime, criminal act, assault or felonious behavior. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a covered medical (including both physical and mental health) condition.

W. **Impotence/Sexual Dysfunction**. Care, treatment, services, supplies or medication in connection with treatment for erectile dysfunction, anorgasmia, premature ejaculation or other condition resulting in the inability to engage in normal sexual activity.

X. **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

Y. **Missed appointments.** Fees related to missed appointments will not be covered.

Z. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

AA. **Non-compliance**. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice or leaves a Medical Facility without official discharge/release.

BB. **Non-emergency Hospital admissions**. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

CC. **No obligation to pay**. Charges incurred for which the Plan has no legal obligation to pay.

DD. **No Physician recommendation**. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

EE. **Not specified as covered**. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

FF. **Obesity**. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered. Charges for group counseling, nutritional supplements, registration payments and fees are not considered covered expenses.

GG. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

HH. **Personal comfort items**. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription Drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

II. **Plan design exclusions**. Charges excluded by the Plan design as mentioned in this document.

JJ. **Pregnancy of a dependent child.** Related to the pregnancy of a dependent child. Certain services that are included under Preventive Care may be eligible for coverage.

KK. **Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse except to the extent that services are rendered by an actively licensed nurse (R.N., L.P.N., or L.V.N.) The services must be Medically Necessary. Coverage is not provided for a nurse who is a relative, family member, or a sitter. Coverage is also not available for private duty nursing in a hospital if the services are ordinarily provided by the hospital nursing staff.

LL. **Relative giving services**. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

MM. **Replacement braces**. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

NN. **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

OO. **Sex changes**. Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a Participant’s physical characteristics from the Participant’s biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.

PP. **Sleep disorders.** Care and treatment for sleep disorders, including biofeedback, unless deemed Medically Necessary.

QQ. **Surgical sterilization reversal**. Care and treatment for reversal of surgical sterilization.

RR. **Surrogate expenses.** Care, treatment, and services related to the treatment of the surrogate parent and the child born of a surrogate parent. Surrogacy usually refers to a woman’s Pregnancy who,

usually by way of a pre-arranged legal contract, agrees to be artificially inseminated with the semen of another woman's husband/partner, conceive a child, carry it to term, and after its birth surrender it to the natural father and his wife/partner, regardless whether payment is part of the agreement.

SS. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge, except where specifically stated for transplant coverage.

TT. **War.** Any loss that is due to a declared or undeclared act of war or terrorism.

Cost Management Services

Cost Management Services Phone Number

Maestro Health
(855) 522-1824

Because communication is the basis for the program, the Plan requires that you contact the Pre-certification Program administrator before any non-emergency inpatient admission. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.** The Plan will provide coverage only for inpatient stays which are determined to be medically necessary for treatment of a covered illness or injury.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

A. Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

a. Inpatient Hospitalizations
b. Bletharoplasty / Ptosis repair
c. Botox Injections
d. Breast Reduction Surgery
e. Mastectomy or oophorectomy, prophylactic, risk reduction
f. Dialysis
g. DME over $1,000
h. Home Health Care
i. Home Infusion Therapy
j. Hysterectomy
k. Laminectomy*Discectomy*Spinal Fusion*Vertabroplasty
l. Panniculectomy (removal of excess skin)
m. PET scans (position emission tomography)
n. Prosthetic Appliances (over $1,000) including Cochlear Implants
o. Private Duty Nursing
p. Skilled Nursing facility
q. Synvisc/ Supartz Inj. (for osteoarthritis of the knee)

r. Transplants

s. Treatment of OSA (Surgery, CPAP or BIPAP, not to include sleep studies)

t. UPPP or Somnoplasty (uvulopalatopharyngolasty)

u. Varicose Vein Surgery

B. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

C. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

D. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

Urgent Care or Emergency Admissions

Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program. For urgent, emergency admissions, follow your physician's instructions carefully, and contact the Pre-certification Program administrator within 48 hours of the first business day following admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification is still encouraged at the time of admission, and is required for any hospital stay that is in excess of the minimum length of stay. Failure to notify the Pre-certification Program administrator within 24 hours of any stay that is in excess of the minimum length of stay will result in application of a penalty to the hospital expenses. For a hospital stay that exceeds the time limits specified under federal law on a holiday or after 5:00 P.M. on Friday, contact must be made on the next regular business day. No penalty will be applied to your benefits if contact is made within this time period.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. The Utilization Review administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

In order to maximize Plan reimbursements, the following provisions should be read carefully.

Precertification

Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other medical services the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person or his/her authorized representative or provider of service. The utilization review administrator should be contacted at the telephone number on the Covered Person's ID card **before** services are scheduled to be rendered with the following information:

A. The name of the patient and relationship to the covered Retired Employee

B. The name, personal identification number and address of the covered Retired Employee

C. The name of the Employer

D. The name and telephone number of the attending Physician

E. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay

F. The diagnosis and/or type of surgery

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility, attending Physician, or authorized representative must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If you fail to notify the Utilization Review administrator within the time periods stated above for emergency and non-emergency care, the benefits that otherwise would be available for the expenses under the Plan will be reduced as follows:

- Benefits otherwise payable will be calculated, then reduced by $500, and this amount will not accumulate toward any deductibles or out-of-pocket expense limits.

A precertification or concurrent review determination under this section will not be guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

Concurrent Review, Discharge Planning

Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days. If the additional services or days are not authorized by the utilization review program, the Hospital charges for those non-authorized days may/will not be payable under the Plan.

SECOND AND/OR THIRD OPINION PROGRAM

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

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be considered as any other Sickness.

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

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

- **A.** Appendectomy
- **B.** Cataract Surgery
- **C.** Cholecystectomy (gall bladder removal)
- **D.** Deviated septum (nose surgery)
- **E.** Hemorrhoidectomy
- **F.** Hernia surgery
- **G.** Hysterectomy
- **H.** Mastectomy surgery
- **I.** Prostate surgery
- **J.** Spinal Surgery
- **K.** Surgery to Knee, Shoulder, elbow or toe
- **L.** Tonsillectomy and adenoidectomy
- **M.** Tympanotomy (inner ear)
- **N.** Salpingo-oophorectomy
- **O.** Varicose vein ligation

PRE ADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

- **A.** performed on an outpatient basis within seven days before a Hospital confinement;
- **B.** related to the condition which causes the confinement; and
- **C.** performed in place of tests while Hospital confined.

Covered charges for this testing will be considered as outlined on the Schedule of Medical Benefits, even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits provided under "Case Management" shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

In certain circumstances, especially in the case of a very serious illness or injury, the Plan may make available its Case Management Program services to the covered person. This is strictly a voluntary program; no covered person is obligated to participate and benefits will not be adversely affected. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

The Case Management Program is administered by Maestro Health. Case managers are medical professionals who will work with your attending physician to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your physician throughout the course of treatment. If you have any questions about the Case Management Program, please feel free to contact Maestro Health at (855) 522-1824.

Prescription Drug Benefits

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. PharmAvail is the administrator of the pharmacy drug plan.

COPAYMENTS

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the Schedule of Benefits. The copayment amount is not a covered charge under the medical Plan. Any one pharmacy prescription is limited to a 90-day supply or a 300-unit dose. Any one mail order prescription is limited to a 90-day supply or a 300-unit dose.

ANNUAL OUT-OF-POCKET MAXIMUM

An out-of-pocket maximum is the most a member will have to pay in co-insurance and copayments during a plan year for medications. Once a member has reached his or her out-of-pocket maximum, the plan begins to pay 100 percent of the allowed amount for covered drugs.

	OUT OF POCKET MAX	
PLAN	INDIVIDUAL	FAMILY
Retiree Only	$1,000	
Retiree + Spouse	$1,000	$2,000
Retiree + Child	$1,000	$3,000
Retiree + Family	$1,000	$4,000

Once a family member has pharmacy expenses totaling the individual limit ($1,000), the plan begins paying 100% of all covered medication costs for that member.

The family limit is cumulative for all family members. The family out of pocket maximum can be met by a combination of family members; however, no single individual within the family will be subject to more that the individual limit amount. When medication expenses added together meet the family maximum, the plan begins paying 100% of all covered medication costs for the entire family.

Some expenses do not count toward the pharmacy out-of-pocket maximum, including insurance premiums, balancing billing amounts, expenses for non-covered pharmacy items, and expenses associated with covered and non-covered medical services and supplies.

MAIL ORDER DRUG BENEFIT OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

If a generic drug equivalent is not available, or your physician has ordered the prescription to be “dispensed as written”, covered drugs will be reimbursed at the preferred brand name drug benefit shown in the schedule. If you choose a brand name drug when a generic is available, you will be required to pay the 100% of the discounted ingredient cost of the brand name drug.

COVERED PRESCRIPTION DRUGS

A. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, the birth control patch, and other forms of prescription contraceptives, but excludes any drugs stated as not covered under the Plan. Self-injectable drugs (except insulin, Imitrex and Epipens) require prior authorization from Maestro Health.

B. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

C. Smoking/Tobacco Cessation products, prescription and OTC. OTC smoking/tobacco cessation products allowed at generic copay. OTC smoking/tobacco cessation products unlimited for first 6 consecutive calendar months.

LIMITS TO THIS BENEFIT

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

A. Refills only up to the number of times specified by a Physician.

B. Refills up to one year from the date of order by a Physician.

C. Brand or Generic prescription medications will not be covered if there is an over-the-counter alternative available.

D. Brand Medications will be excluded when there is a generic available, unless determined to be medically necessary. In such cases, the cost differential between the brand and the generic prescription will be the responsibility of the member.

EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

A. **Administration.** Any charge for the administration of a covered Prescription Drug.

B. **Acne medications.**

C. **Antihistamines**

D. **Consumed on premises**. Any drug or medicine that is consumed or administered at the place where it is dispensed.

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

F. **Drugs used for cosmetic purposes**. Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

G. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

H. **FDA**. Any drug not approved by the Food and Drug Administration.

I. **Growth hormones**. Charges for drugs to enhance physical growth or athletic performance or appearance.

J. **Homeopathic Legend Products.**

K. **Immunization.** Immunization agents or biological sera.

L. **Implantable contraceptives.**

M. **Impotence/Sexual Dysfunction.** A charge for impotence or sexual dysfunction treatment.

N. **Infertility.** A charge for infertility medication.

O. **Injectable supplies**. A charge for hypodermic syringes and/or needles (except for insulin).

P. **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

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

R. **Medical exclusions.** A charge for expenses that are excluded under Medical Plan Exclusions.

S. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

T. **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

U. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin, alcohol swabs, lancets, urine/blood test strips and tapes.

V. **Pregnancy Termination Drugs.**

W. **Proton Pump Inhibitors.**

X. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Y. **Vitamins,** with the exception of prescription vitamins, and vitamin A derivatives.

Dental Benefits

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the individual Plan Year deductible amount shown in the Schedule of Benefits has been satisfied by three members of a Family Unit, the deductibles of all remaining members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM PLAN YEAR BENEFIT AMOUNT

The Maximum Plan Year dental benefit amount is shown in the Schedule of Benefits.

Maximum Benefit for Temporomandibular Joint Dysfunction (TMJ) Treatment: The maximum benefit payable, while covered under this Plan, for treatment of temporomandibular joint dysfunction is shown in the Schedule of Benefits. Any benefits applied to this maximum will also be applied to the Maximum Plan Year Benefit Amount for the Plan Year in which the expense is incurred.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

PENALTY FOR LATE ENROLLEES

Class II Restorative Dental Services will not be covered during the first six (6) months following a Late Enrollee's effective date under this Plan. Class II Non-Restorative Dental Services will not be covered during the first twelve (12) months following a Late Enrollee's effective date under this Plan. Class III Dental Services will not be covered during the first twenty-four (24) months following a Late Enrollee's effective date under this Plan. This limitation will not apply to covered expenses due solely to an injury while covered under this Plan. Expenses not covered due to this limitation will not be considered covered expenses and cannot be used to satisfy the Plan's Calendar Year deductible.

A Late Enrollee is a person who becomes covered under this Plan more than 31 days after he or she is eligible or who becomes covered again after his or her coverage lapsed due to non-payment of required premium contributions.

If treatment for a service limited under this provision is started during the Late Enrollee limitation period, only the portion of the treatment rendered after the end of the Late Enrollee limitation period will be considered a covered dental expense.

COVERED DENTAL SERVICES

Class I Services: Preventive Dental Procedures

The limits on Class I services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

A. **Routine oral exams.** This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Plan Year One bitewing x-ray series every Plan Year.

B. One full mouth **x-ray** every 60 consecutive months.

C. Two **fluoride treatments** for covered Dependent children under age 14 each Plan Year.

D. **Space maintainers**, including all adjustments made within 6 months of installation, for covered Dependent children under age 19.

E. **Sealants** on the occlusal surface of a permanent posterior tooth for Dependent children under age 14, once per tooth in any 36 consecutive months.

Class II Services: Basic Dental Procedures- Non Restorative

A. Emergency oral exams, considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit.

B. Intraoral periapical x-rays; intraoral occlusal x-rays (limited to one film in any 6-month period); extraoral x-rays (limited to one film in any 6-month period); other x-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction).

C. Histopathological examination.

D. Stainless steel crowns, limited to:

a. 1 time in any 36-month period;

b. teeth not restorable by an amalgam or composite filling; and

c. covered dependent children less than age 19.

E. Pulpotomy.

F. Root canal therapy, including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period.

G. Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care.

H. Retrograde filling - per root.

I. Root amputation - per root.

J. Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.

K. Periodontal scaling and root planing (per quadrant), limited to 1 time per quadrant of the mouth in any 24-month period.

L. Periodontal maintenance procedure (following active treatment), limited to 1 dental prophylaxis or 1 periodontal maintenance procedure in any 6-month period.

M. Periodontal related services as listed below, limited to 1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period:

a. gingivectomy;

b. gingival curettage;

c. mucogingival or osseous surgery.

N. Osseous grafts; pedicle grafts; tissue grafts.

O. Periodontal appliances, limited to 1 appliance in any 12-month period.

P. Simple extraction.

Q. Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:

a. surgical extractions (including extraction of wisdom teeth);

b. alveoloplasty;

c. vestibuloplasty;

d. removal of exostosis -maxilla or mandible;

e. frenulectomy (frenectomy or frenotomy);

f. excision of hyperplastic tissue - per arch;

g. tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus.

R. Root removal - exposed roots.

S. Biopsy.

T. Incision and drainage.

U. Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit.

V. General anesthesia and intravenous sedation, limited as follows: considered for payment as a separate benefit only when determined medically necessary and when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the Plan.

W. Consultation, including specialist consultations, limited as follows:

a. considered for payment only if billed by a dentist who is not providing operative treatment;

b. benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan.

X. Therapeutic drug injections.

Class II Services: Basic Dental Procedures - Restorative

A. Amalgam restorations, limited as follows:

a. multiple restoration on one surface will be considered a single filling;

b. benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least:

c. 12 months have passed since the existing amalgam restoration was placed if the Covered Person is less than age 19; or

d. 36 months have elapsed since the existing amalgam restoration was placed if the Covered Person is age 19 or older;

e. mesial, lingual, buccal (MLB) and distal, lingual, buccal (DBL) restorations will be considered single surface restorations.

B. Silicate restorations.

C. Plastic restorations.

D. Composite restorations, limited as follows:

a. mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations;

b. acid etch is not covered as a separate procedure;

c. benefits for replacement of an existing composite restoration will only be considered for payment if at least:

i. (12 months have passed since the existing composite restoration was placed if the Covered Person is less than age 19; or

ii. 36 months have passed since the existing composite restoration was placed if the Covered Person is age 19 or older;

iii. benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration.

E. Pin retention restorations, covered only in conjunction with an amalgam or composite restoration, pins limited to 1 time per tooth.

Class III Services: Major Dental Services

All benefits for the services listed will include an allowance for all temporary restorations and appliances, and 1 year of follow-up care.

A. Inlays and onlays;

a. covered only when the tooth cannot be restored by an amalgam or composite filling;

b. covered only if more than 10 years have elapsed since last placement; and

c. limited to persons over age 16.

B. Porcelain restorations on anterior teeth.

C. Crowns;

a. covered only when the tooth cannot be restored by an amalgam or composite filling;

b. covered only if more than 10 years have elapsed since last placement; and

c. limited to persons over age 16.

D. Recementing inlays.

E. Recementing crowns.

F. Crown build-up, including pins and prefabricated posts.

G. Post and core, covered only for endodontically treated teeth requiring crowns.

H. Endodontic endosseous implant and endosseous implant. Benefits for the replacement of an existing implant are payable only if the existing implant is more than 10 years old and it cannot be made serviceable.

I. Full dentures, limited as follows:

a. limited to 1 time per arch unless:

b. 10 years have elapsed since last placement; and

c. the denture cannot be made serviceable;

d. additional benefits will not be paid for personalized dentures or overdentures or associated treatment;

e. any denture will not be paid until it is accepted by the patient.

J. Partial dentures, including any clasps and rests and all teeth, limited as follows:

a. limited to 1 partial denture per arch unless:

b. 10 years have elapsed since last replacement (see Denture or Bridge Replacement/Addition provision for exceptions); and

c. the partial denture cannot be made serviceable;

d. there are no benefits for precision or semi-precision attachments.

K. Denture adjustments, limited to 1 time in any 12-month period, and adjustments made more than 12 months after the insertion of the denture.

L. Repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustments performed more than 12 months after the initial installation.

M. Relining or rebasing dentures, limited to 1 time in any 36-month period and relining and rebasing done more than 12 months after the insertion of the denture.

N. Tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture.

O. Fixed bridges (including Maryland bridges), limited as follows:

a. limited to person over age 16;

b. benefits for the replacement of an existing fixed bridge are payable only if the existing bridge:

c. is more than 10 years old (see Denture or Bridge Replacement/Addition provision for exceptions); and

d. cannot be made serviceable;

e. a fixed bridge replacing the extracted portion of a hemisected tooth is not covered;

f. the date the bridge is cemented in the mouth will be used in determining the amount that will be applied to the Plan Year Maximum shown in the Dental Plan Schedule of Benefits.

P. **Recementing bridges**, limited to repairs or adjustment performed more than 12 months after the initial insertion.

Q. **Non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ)** for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the Temporomandibular Joint including treatment of the chewing muscles to relieve pain or muscle spasm, TMJ x-rays, and occlusal adjustments, limited as follows:

a. coverage does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis or muscle testing;

b. the Lifetime Maximum for Temporomandibular Joint Dysfunction (TMJ) Treatment and the Plan Year Maximum shown in the Dental Plan Schedule of Benefits will apply.

R. Implants, including surgical insertion or removal of implants.

DENTURE OR BRIDGE REPLACEMENT/ADDITION

As stated in the Covered Dental Expenses section, benefits will not be paid for the replacement of a full denture, partial denture, fixed bridge or for teeth added to a partial denture unless 10 years have elapsed since last replacement of the denture or bridge and the denture or bridge cannot be made serviceable.

However, the following exceptions will apply:

A. benefits for the replacement of an existing partial denture that is less than 10 years old will be payable if there is a dentally necessary extraction of an additional functioning natural tooth;

B. benefits for the replacement of an existing fixed bridge that is less than 10 years old will be payable if there is a dentally necessary extraction of an additional functioning natural tooth and the extracted tooth was not an abutment to an existing bridge.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $300 or more, a predetermination of benefits form should be submitted.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Maestro Health
P. O. Box 1178
Matthews, NC 28106

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If

verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

DENTAL DEFINITIONS

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a dentist within the scope of the license in treating the dental condition.

Dentally necessary and dental necessity mean a treatment appropriate for the diagnosis and in accordance with accepted dental standards. The treatment must be essential for the care of the teeth and supporting tissues.

Dental treatment plan means the dentist's report of recommended treatment which contains a list of the charges and dental procedures required for the dentally necessary care, any supporting x-rays, and any other appropriate diagnostic materials required.

Dentist means an individual who is licensed to practice dentistry and acting with the scope of that license in treating the dental condition.

Emergency dental care means any dentally necessary treatment rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

Functioning natural tooth means a natural tooth which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another natural tooth or prosthetic replacement.

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food).

Predetermination of benefits means review of a dentist's statement, including diagnostic x-rays, describing the planned treatment and expected charges.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissue.

EXCLUSIONS

A charge for the following is not covered:

A. **Administrative costs**. Administrative costs of completing claim forms or reports or for providing dental records.

B. **Broken appointments.** Charges for broken or missed dental appointments.

C. **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

D. **Hospital charges.** Hospital or facility charges for room, supplies or emergency room expenses; or routine chest x-rays and medical examinations prior to oral surgery.

E. **Hygiene**. Oral hygiene, plaque control programs or dietary instructions.

F. **No listing.** Services which are not included in the list of covered dental services.

G. **Orthodontia**. Orthodontic treatment and orthognathic surgery.

H. **Personal supplies.** Charges for personal supplies or equipment, including, but not limited to, water piks, toothbrushes, or floss holders.

I. **Personalization**. Personalization of dentures.

J. **Replacement.** Replacement of lost or stolen appliances.

K. **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

L. **Treatment outside of the United States**. Charges for services performed outside of the United States except for emergency dental care. The maximum benefit payable to any person during a Plan Year for covered dental expenses related to emergency dental care performed outside of the United States is $100.

Defined Terms

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. For purposes of satisfying the Waiting Period only, absence due to Injury, Illness or disability will not preclude an Employee from being considered an Active Employee provided he or she was actively employed the day preceding the absence.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Benefit Period; Benefit Year means July 1st through June 30th of the following year.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Claimant means a person who is or was a covered eligible Retired Employee or a covered eligible Dependent of a Retired Employee.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Cochlear Implants are not hearing aids. Cochlear Implants are considered Prosthetics for determination of benefits.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Retired Employee or Dependent who is covered under this 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, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dental Benefits are covered dental charges incurred by a person while covered under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent is a spouse or child of the covered Retired Employee who meets the Dependent eligibility requirements of this Plan.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employer is UNION COUNTY.

Enrollment Date is the first day of coverage

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

A. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

B. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

C. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

D. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Retired Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the administrator of the pharmacy drug plan of safe, effective therapeutic drugs specifically covered by this Plan. The administrator of the pharmacy drug plan is listed in the Prescription Drug Benefits section of the Plan.

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Retired Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Retired Employee's; the child depends on the covered Retired Employee for primary support; the child lives in the home of the covered Retired Employee; and the covered Retired Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Retired Employee's home; one placed in the covered Retired Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

Hazardous Pursuit/Hobby is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are sky diving, auto racing, hang gliding, jet ski operation, and bungee jumping. This is not a comprehensive listing of all Hazardous Pursuits excluded by the Plan. The Plan Administrator may, at its sole discretion, determine that expenses related to other unusual, risky activities not aforementioned are excluded from coverage.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

A. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

B. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit, **Cardiac Care Unit or Burn Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Treatment means a structured outpatient program consisting of nine or more hours per week of treatment for Mental Disorder or Substance Abuse. The program must be specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient’s functional level and prevent relapse. The provider must be licensed to provide intensive Outpatient Treatment, if such licensing is required by the state where services are rendered. If not addressed by the Intensive Outpatient Treatment program, the patient’s needs for psychiatric and medical services must be addressed through consultation or referral arrangements.

Late Enrollee means a Plan Participant who, because he/she did not enroll for coverage under the Plan when initially eligible or as a Special Enrollment, enrolls under the Plan during the Open Enrollment Period.

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Maximum Amount and/or Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary and Reasonable amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The **Maximum Allowable** Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medical Benefits are covered medical charges incurred by a person while covered under this Plan.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; to result in serious impairment to bodily functions; or to result in serious dysfunction of any bodily organ or part.

Medical Record Review is the process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the medical record review and audit results.

Medically or Dentally Necessary
"Medically Necessary" means services or supplies which are determined by the Plan Administrator to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical or dental condition, injury or illness;
- Provided for the diagnosis or direct care and treatment of the medical or dental condition, injury or illness;
- Within standards of good medical practice within the organized medical or dental community;
- Not primarily for the convenience of the covered person, the Participant's Physician, dentist or another provider; and
- The most appropriate supply or level of service which can safely be provided.

For hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is Medically Necessary. In addition, the fact that

certain services are excluded from coverage under this Plan because they are not Medically Necessary does not mean that any other services are deemed to be Medically Necessary.

Medical necessity for a service or supply will be determined by the Plan based upon industry-standard resources and the standards, policies and procedures established by the Pre-certification Program administrator.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means 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.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Preferred Brand Drug means a Prescription Drug so designated by Caremark CVS, the administrator of the pharmacy drug plan.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D. S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Union County Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan), which is a benefit plan for retired employees of Union County and is described in this document.

Plan Document means the instrument or instruments that set forth and govern the duties of the Plan Administrator and eligibility and benefit provisions of the Plan, which provide for payment or reimbursement of Covered Services.

Plan Participant or Participant is any Retired Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Calendar Year which is a short Calendar Year. For the purposes of this Plan, the Plan Year will be the period July 1 through June 30.

Preferred Brand Drug means a Prescription Drug so designated by the pharmacy benefit manager.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventative Care means charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition that is known or reasonably suspected. Diagnosis and treatment of Illness, Injury and pregnancy related conditions are not Preventive Care.

Primary Care Physician means a family practice physician, a general internist, a pediatrician, or an OB/GYN.

Reasonable and/or Reasonableness shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fees to be considered not Reasonable.

Charge(s) and/or service are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Retired Employee means a Retired Employee of the Employer. Refer to Page 8 of this document for further explanation of the requirements of a retired employee.

Scheduled benefit or Scheduled benefit amount means a specific dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled benefits are based upon covered expenses not otherwise limited or excluded under the terms of the Plan.

Scheduled benefit amounts are determined taking into consideration (but not restricted to) the lesser of the Usual and Customary fee for services and/or supplies, which are deemed to be both Reasonable and Medically Necessary, and:

- For inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values.
- For outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values.
- For physicians and other eligible for Providers, scheduled benefit amounts, the lesser of the scheduled benefit amount or [125%] of the CMS Reimbursement Schedule for the CMS area.
- For Ambulatory Surgical Centers (ASC) the lesser of the scheduled benefit amount or [125%] of the CMS Reimbursement Schedule for the CMS area.
- At the Plan Administrator's discretion, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.
- If The Plan Administrator is unable to determine scheduled benefit amounts utilizing the aforementioned process, it shall, at its sole discretion, determine scheduled benefit amounts considering accepted industry-standard documentation uniformly applied without discrimination to any Plan Participant.

Sickness is:

A. For a covered Retired Employee and covered Spouse: Illness, Disease or Pregnancy.

B. For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

A. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

B. Its services are provided for compensation and under the full-time supervision of a Physician.

C. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

D. It maintains a complete medical record on each patient.

E. It has an effective utilization review plan.

F. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

G. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature that meets the seven (7) criteria listed above.

Smoking/Tobacco Cessation is a program or prescription designed to aid employees and their dependents that are trying to quit smoking.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Transplant is the Transplant of organs from human to human, including bone marrow, stem cell and cord blood transplant. Transplants include only those transplants that: (a) are approved for Medicare coverage on the date the Transplant is performed; and (b) are not otherwise excluded by the Plan.

Usual and Customary (U&C) shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Vision Care means an annual routine eye examination performed by an Ophthalmologist/Optometrist including supplemental contact lens fittings and evaluation fees and or glass fittings including hardware.

Claims Submission

WHAT IS A CLAIM?

For purposes of the Plan's provisions for internal claims and appeals and external review processes, a "claim" for benefits is defined as a request for a plan benefit made by a claimant in accordance with a plan's reasonable procedure for filing benefit claims. A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must send MedCost claims to the following address:

Medcost PPO
P.O. Box 25307
Winston-Salem, NC 27114-5307

All other provider clams may be mailed directly to Maestro Health as follows:

Maestro Health
P. O. Box 1178
Matthews, NC 28106

(855) 522-1824

If a Claim form is required, the Claims Administrator will furnish the necessary form and instructions for its completion.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

A. it's not reasonably possible to submit the claim in that time; and

B. the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

Post-service health claims must be filed with the third party administrator within 12 months of the date charges for the services were incurred. **Claims filed later than that date will be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the third party administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within 45 days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.** The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIM PROCEDURES

You will receive a Plan identification (ID) card, which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Maestro Health
PO Box 1178
Matthews, NC 28106

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

PROCEDURES FOR ALL CLAIMS

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

PROCEDURE FOR DENTAL CLAIMS

A Form HCFA or Form UB completed by the provider of service, or a form approved for use by the ADA, completed by the dentist, including:

- **A.** The date of service;
- **B.** The name, address, telephone number and tax identification number of the provider of the services or supplies;
- **C.** The place where the services were rendered;
- **D.** The diagnosis and procedure codes;
- **E.** The amount of charges (including PPO network repricing information);
- **F.** The name of the Plan;
- **G.** The name of the covered retired employee; and
- **H.** The name of the patient.

TYPES OF CLAIMS

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

Pre-service Claims

A “pre-service claim” is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

Further, if the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

A “concurrent claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan Administrator determines that the course of treatment should be reduced or terminated; or
- The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

Since the Plan does not require the Covered Person to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Covered Person simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Post-service Claims

A “post-service claim” is a claim for a benefit under the Plan after the services have been rendered.

HEALTH CLAIMS

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

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Covered Person has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

TIMING OF CLAIM DECISION

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Non-urgent Care Claims:

If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

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

Concurrent Claims:

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

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

Post-service Claims:

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

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

Extensions

Pre-service Non-urgent Care Claims:

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

Post-service Claims:

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

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

ADVERSE BENEFIT DETERMINATIONS

An "adverse benefit determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on:

- **A.** A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- **B.** A determination that a benefit is not a covered benefit;
- **C.** The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
- **D.** A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

A. Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

B. The reason or reasons for an adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;

C. A reference to the specific portion(s) of the plan document and summary plan description upon which a denial is based;

D. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

E. A description of the Plan's review procedures and the time limits applicable to the procedures;

F. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

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

H. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

I. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), 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 to the claimant, free of charge, upon request.

Internal Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

A. Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;

B. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

C. Claimants the opportunity to review the claim file and to present evidence and testimony as part of the internal claims and appeals process;

D. That a claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal adverse benefit determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale;

E. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

F. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;

G. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

H. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

I. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or third party administrator; information regarding any voluntary appeals procedures offered by the Plan; information regarding the claimant's right to an external review process; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances.

How to Appeal

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The Plan provides for two levels of internal appeals.

For questions about appeal rights or for assistance, claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your state. Contact your state Department of Insurance to find out if consumer assistance for claim appeals is available.

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

Maestro Health
PO Box 1178
Matthews, NC 28106
704-845-5629

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

A. The name of the Retired Employee/Covered Person;

B. The Retired Employee/Covered Person's identification number;

C. The group name and/or group number;

D. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;

E. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

F. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

First Internal Appeal Level

A. Requirements for First Internal Appeal

The Covered Person must file the first internal appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include the information described in the section above, "How to Appeal". If the Covered Person provides all of the required information, it may be that the expense will be eligible for payment under the Plan.

B. Timing of Notification of Benefit Determination on First Internal Appeal

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

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

Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

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

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

C. Manner and Content of Notification of Adverse Benefit Determination on First Internal Appeal

The Plan Administrator shall provide a Covered Person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- Information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
- The reason or reasons for an adverse benefit determination or final internal adverse benefit determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision;
- A reference to the specific portion(s) of the plan document and summary plan description upon which a denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

- A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;
- A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures;

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."

D. Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide, upon request and free of charge, such reasonable access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Internal Appeal" as appropriate.

Second Internal Appeal Level

A. Adverse Decision on First Appeal; Requirements for Second Internal Appeal

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

B. Timing of Notification of Benefit Determination on Second Internal Appeal

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

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

b. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service non-urgent or post-service.

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

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

C. Manner and Content of Notification of Adverse Benefit Determination on Second Internal Appeal

The same information must be included in the Plan's response to a second internal appeal as a first internal appeal, except for:

a. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is needed; and

b. A description of the Plan's internal appeal review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Internal Appeal."

c. A notification of adverse benefit determination for an internal appeal will include an explanation of the Covered Person's opportunity for a full and fair external review as set forth below in the section, "External Review of Adverse Benefit Determinations".

D. Furnishing Documents in the Event of an Adverse Determination

a. In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide, upon request and free of charge, such reasonable access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Internal Appeal" as appropriate.

E. Decision on Second Internal Appeal

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

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS

When the internal appeals procedures have been exhausted, the Covered Person may elect to have an additional and final opportunity for a review of an adverse benefit determination (including a final internal adverse benefit determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Covered Person within four months following the Covered Person's receipt of the notice of adverse benefit determination or final internal adverse benefit determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the Covered Person will be deemed to have exhausted the internal claims and appeals process, and the Covered Person may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Plan's external review process applies to any adverse benefit determination or final internal adverse benefit determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

There are two types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services but has not yet been discharged from the facility. In such cases, the Plan will consider the external review to be an expedited review.

Expedited External Review for Urgent or Emergency Care

This Plan does not require a Covered Person to obtain prior approval for pre-service urgent care claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these claims. In an emergency or urgent care situation, the Covered Person should follow instructions from his or her health care provider, and file the claim as a post-service claim. If the post-service claim results in an adverse benefit determination, the Covered Person may file an appeal in accordance with the Plan's provisions for "How to Appeal", which are explained above.

Appeals of concurrent claims will be subject to the Plan's provisions for expedited external review, as explained below.

Procedures for Initiation of an External Review

A. Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "How to Appeal".

Once the request for a standard external review is filed, the Plan will have five business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one business day following completion of the preliminary review, the Plan will notify the Covered Person in writing whether the request is eligible for external review.

a. If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

b. If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The Covered Person must submit the information or materials needed within 48 hours following receipt of the notice, or the expiration of the original four-month filing period, whichever is later.

An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review.

The assigned IRO will notify the Covered Person in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Covered Person may submit to the IRO, in

writing and within 10 business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the adverse benefit determination or final internal adverse benefit determination. In this case, the IRO will notify the Plan and the Covered Person within one business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the Covered Person to the Plan, and the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its adverse benefit determination or final internal adverse benefit determination, it may terminate the external review and notify the IRO and the Covered Person within one business day of the decision.

The IRO will provide written notice to the Covered Person and the Plan of the final external review decision with 45 days following receipt of the request for review. The notice will contain:

a. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

b. The date the IRO received the request for external review and the date on which it made the decision;

c. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;

e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Covered Person;

f. A statement that judicial review may be available to the Covered Person; and

g. Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

B. Expedited External Review

A final internal adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which the Covered Person received emergency services but has not yet been discharged from the facility will be considered for an expedited external review. These are considered to be pre-service non-urgent care claims and concurrent claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

a. The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the Covered Person regarding the eligibility determination;

b. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;

c. The Plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

d. The IRO must provide notice of the final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the Covered Person and the Plan within 48 hours following the notice.

C. Decision Following an External Review

Upon receipt of a notice from the IRO reversing the decision of an adverse benefit determination or final internal adverse benefit determination, the Plan will immediately provide coverage or payment for the claim. An external review decision is binding on the Plan as well as the Covered Person, except to the extent other remedies are available under State or Federal law.

LEGAL ACTION

All internal and external claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the third party administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

PHYSICAL EXAMINATIONS

The Plan reserves the right to have a physician of its own choosing examine any Covered Person whose illness or injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose illness or injury is the basis of a claim. This right may be exercised only where not prohibited by law.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the covered retired employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered retired employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such retired employee.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the retired employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

NON-U.S. PROVIDERS

Medical expenses for care, supplies or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "non-U.S. provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

A. Benefits may not be assigned to a non-U.S. provider;

B. The Covered Person is responsible for making all payments to non-U.S. providers, and submitting receipts to the Plan for reimbursement;

C. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;

D. The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and

E. Claims for benefits must be submitted to the Plan in English.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or dependent on whose behalf such payment was made.

A Covered Person, dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and

whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

MEDICAID COVERAGE

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

Coordination of Benefits

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- **A.** Group or group-type plans, including franchise or blanket benefit plans.
- **B.** Blue Cross and Blue Shield group plans.
- **C.** Group practice and other group prepayment plans.
- **D.** Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- **E.** Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- **F.** No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

- **A.** Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- **B.** Plans with a coordination provision will pay their benefits up to the Allowable Charge:
    - a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
    - b. The benefits of a benefit plan, which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an

Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

C. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

a. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

b. If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

D. When a child's parents are divorced or legally separated, these rules will apply:

a. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

b. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

c. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

d. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

E. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

F. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

G. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D benefits.

H. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

I. The Plan will pay primary to Tricare to the extent required by Federal law.

Claims determination period. Benefits will be coordinated on a Benefit Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

Coordination of Benefits with Medicare
Coordination of benefits with Medicare will conform with Federal law. Your benefits under this Plan will be secondary to Medicare to the extent allowed by Federal law.

Failure to Notify Plan Administrator of Other Coverage. Should a Plan Participant become entitled to coverage under another group health plan, or entitled to benefits under Medicare, and subsequently fail to notify the Plan Administrator within fifteen (15) days of the date he/she first becomes entitled to other coverage after the date of COBRA election (the "Notification Period"), the Plan expressly reserves the right to retroactively cancel COBRA coverage and seek reimbursement of all benefits paid after the date of expiration of the Notification Period. The Plan shall refund any COBRA premiums remitted less any claims paid, subsequent to the date of expiration of the Notification Period.

SUBROGATION, THIRD PARTY RECOVERY AND REIMBURSEMENT PROVISION

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

When this Provision Applies
A covered person may incur medical or other charges related to injuries or illness caused by the act or omission of another person; or another party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness. If so, the covered person may have a claim against that other person or another party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the covered person may have against that other person or another party and will be entitled to reimbursement. In addition, the Plan shall have the first lien against any recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision, except to the extent of the Plan's Pro Rata Share of Attorneys' Fees. The Plan's first lien supersedes any right that the covered person may

have to be "made whole." In other words, the Plan is entitled to the right of first reimbursement out of any recovery the covered person procures or may be entitled to procure regardless of whether the covered person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, except to the extent of the Plan's Pro Rata Share of Attorneys' Fees. As a condition to receiving benefits under the Plan, the covered person agrees that acceptance of benefits is constructive notice of this provision.

The covered person must:

- Execute and deliver a subrogation and reimbursement agreement;

- Authorize the Plan to sue, compromise and settle in the covered person's name to the extent of the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the covered person's rights to recovery when this provision applies;

- Immediately reimburse the Plan, out of any recovery made from another party, 100% of the amount of medical or other benefits paid for the injuries or illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise), except to the extent of the Plan's Pro Rata Share of Attorneys' Fees;

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

- Promptly respond to any information requests made by the Claims Administrator including, but not limited, to Subrogation Inquiry forms, Health Coverage Inquiry forms and Dependent Eligibility inquiries.

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

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other illnesses or injuries), the covered person will execute and deliver all required instruments and papers, including a subrogation and reimbursement agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of subrogation and reimbursement, before any medical or other benefits will be paid by the Plan for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injuries or illness before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the Plan still will be entitled to subrogation and reimbursement. In addition, the covered person will do nothing to prejudice the Plan's right to subrogation and reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A covered person who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because the covered person is not the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to subrogation or reimbursement. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or other benefits paid for the injuries or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the covered person does not receive full compensation for all of his charges and expenses, except to the extent of the Plan's Pro Rata Share of Attorneys' Fees.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a covered person may receive a recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the recovery. This Plan will not cover any expenses for which compensation was provided through a previous recovery. This exclusion will apply to the full extent of such recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the covered person to inform the Plan Administrator when expenses are related to an illness or injury for which a recovery has been made. Acceptance of benefits under this Plan for which the covered person has received a recovery will be considered fraud, and the covered person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The covered person is required to submit full and complete documentation of any such recovery in order for the Plan to consider eligible expenses that exceed the recovery.

"Another Party"

"Another party" shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a covered person's injuries or illness.

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

"Recovery"

"Recovery" shall mean any and all monies paid to the covered person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. Any recovery shall be deemed to apply, first, for reimbursement, except to the extent of the Plan's Pro Rata Share of Attorneys' Fees.

"Subrogation"

"Subrogation" shall mean the Plan's right to pursue the covered person's claims for medical or other charges paid by the Plan against another party.

"Reimbursement"

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

"Plan's Pro Rata Share of Attorneys' Fees"

"Plan's Pro Rata Share of Attorneys' Fees" shall mean an amount up to 25% of the amount subject to reimbursement to the Plan under this section, which may be deducted from any recovery as the Plan's pro rata share of the covered person's attorneys' fees. In the event the covered person agrees on a lesser percentage to be paid to his attorney, then the Plan's percentage share shall be reduced accordingly. In no event will the Plan share in the payment of any other amounts, such as fees equal to a greater percentage or any costs and expenses incurred by the covered person or his attorney in pursuing the recovery. Any amounts due to the covered person's attorney in excess of the Plan's Pro Rata Share of Attorneys' Fees shall be the responsibility of the covered person.

When a Covered Person retains an Attorney

If the covered person retains an attorney, that attorney must sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the covered person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of recovery. The Plan will pay the covered person's attorneys' fees and costs associated with the recovery of funds, only to the extent of the Plan's Pro Rata Share of Attorneys' Fees.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. A covered person's attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the covered person nor his attorney is the rightful owner of the recovery and should not be in possession of the recovery until the Plan has been fully reimbursed. For purposes of this paragraph, "recovery" shall be deemed to include the phrase, "except to the extent of the Plan's Pro Rata Share of Attorneys' Fees."

When the Covered Person is a Minor or is Deceased

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor covered person and to the heir or personal representative of the estate of a deceased covered person, regardless of applicable law and whether or not the representative has access or control of the recovery.

When a Covered Person Does Not Comply

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

COVERAGE TERMINATION AND CONTINUATION RIGHTS

Termination of Coverage

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. Please contact the Plan Administrator for further details.

Should the Employer continue to receive contributions from the Retired Employee after coverage has terminated, in no way is this action to be construed as the Employer's intent to extend Plan benefits beyond the coverage termination date noted below for Retired Employee or Dependent.

WHEN RETIRED EMPLOYEE COVERAGE TERMINATES

Retired Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Retired Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, the section entitled Continuation Coverage Rights under COBRA should be consulted):

The date Retired Employee coverage terminates:

- **A.** The date on which the covered Retired Employee ceases to be in one of the Eligible Classes. This includes death.
- **B.** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- **C.** The last day of the month immediately preceding (i) a covered Retired Employee's 65th birthday or (ii) the date a covered Retired Employee meets the eligibility requirements for Medicare Part B.

WHEN DEPENDENT COVERAGE TERMINATES

A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA.

- **A.** The date the Plan or Dependent coverage under the Plan is terminated.
- **B.** The date on which the Retired Employee's coverage under the Plan terminates for any reason including death. (the Continuation Coverage Rights under COBRA should be consulted)
- **C.** The last day of the month immediately preceding (i) a covered Dependent's 65th birthday or (ii) the date a covered Dependent meets the eligibility requirements for Medicare Part B. This provision does not apply to dependents who were (1) enrolled in Medicare Part B prior to October 1, 2018 and (2) covered under the Plan prior to October 1, 2018.
- **D.** The end of the pay period in which a covered spouse loses coverage due to loss of dependency status. (the Continuation Coverage Rights under COBRA should be consulted)
- **E.** On the end of the pay period in which a Dependent child ceases to be a Dependent as defined by the Plan. (the Continuation Coverage Rights under COBRA should be consulted)
- **F.** The end of the month of which a dependent child reaches age 26

G. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Retired Employees and their families covered under Union County's Group Health Insurance Program For Retirees (Retired Employee Health Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. Note, however, that in most cases Health Savings Accounts (HSAs) are not subject to Continuation Coverage under COBRA. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is:	COBRA continuation coverage for the Plan is administered by:
Union County 500 North Main Street, Suite 130 Monroe, North Carolina 28112 (704) 283-3869	Maestro Health P. O. Box 1178 Matthews, NC 28106 (855) 522-1824

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

A. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Retired Employee, the spouse of a covered Retired Employee, or a Dependent child of a covered Retired Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

B. Any child who is born to or placed for adoption with a covered Retired Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

An individual is not a Qualified Beneficiary if the individual's status as a covered Retired Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Retired Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

A Qualifying Event is any of the following if the Plan provided that the Plan Participant would lose coverage (i.e. cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

A. The death of a covered Retired Employee

B. The divorce or legal separation of a covered Retired Employee from the Retired Employee's spouse. If the Retired Employee reduces or eliminates the Retired Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

C. A covered Retired Employee's enrollment in any part of the Medicare program.

D. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Retired Employee, or the covered spouse or a Dependent child of the covered Retired Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences) the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Retired Employee, or the spouse, or a Dependent child of the covered Retired Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

What factors should be considered when determining to elect COBRA continuation coverage?

A Covered Person should take into account that a failure to continue group health coverage will affect his or her rights under federal law. First, he or she can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help avoid such a gap. Second, if the Covered Person does not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to him or her, he or she will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing

condition exclusions. Finally, the Covered Person should take into account that he or she has special enrollment rights under federal law (HIPAA). He or she has the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by his or her spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. A Covered Person will also have the same special right at the end of COBRA continuation coverage if he or she gets COBRA continuation coverage for the maximum time available to him or her.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

The Trade Act of 2002 created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Questions about these new tax provisions may be directed to the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

A. death of the Retired Employee,

B. commencement of a proceeding in bankruptcy with respect to the Employer, or

C. enrollment of the Retired Employee in any part of Medicare.

IMPORTANT

For the other Qualifying Events (divorce or legal separation of the Retired Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person or someone on his or her behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. This notice must be sent to the COBRA Administrator.

NOTICE PROCEDURES

Any notice that is provided must be in writing. Oral notice, including notice by telephone, is not acceptable. An individual must mail, fax or hand-deliver the notice to the person, department or firm listed below, at the following address:

Maestro Health
P. O. Box 1178
Matthews, NC 28106

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

A. the name of the Plan or Plans under which coverage is lost or is being lost,

B. the name and address of the Retired Employee covered under the Plan,

C. the name(s) and address(es) of the Qualified Beneficiary(ies), and

D. the Qualifying Event and the date it happened.

If the Qualifying Event is a divorce or legal separation, the notice must include a copy of the divorce decree or the legal separation agreement.

Individuals should be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives timely notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered retired employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If the Qualified Beneficiary, spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

A. The last day of the applicable maximum coverage period.

B. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

C. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Retired Employee.

D. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

E. The date, after the date of the election, which the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

F. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

a. 29 months after the date of the Qualifying Event, or

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

c. or the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

A. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Retired Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

B. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the

original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures noted earlier.

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Retired Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is 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 will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Questions.

Questions about COBRA continuation coverage should be directed to the COBRA Administrator or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). This office may also be contacted if there are questions about a Covered Person’s rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Inform Plan Administrator Of Address Changes

In order to protect the Covered Person's family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. The Covered Person should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

Failure to Notify Plan Administrator of Other Coverage

Should a qualified beneficiary become entitled to coverage under another group health plan, or entitled to benefits under Medicare, and subsequently fails to notify the Plan Administrator within fifteen (15) days of the date he/she first becomes entitled to other coverage after the date of COBRA election (the "Notification Period"), the Plan expressly reserves the right to retroactively cancel COBRA coverage and seek reimbursement of all benefits paid after the date expiration of the Notification Period. The Plan shall refund any COBRA premiums remitted less any claims paid, subsequent to the date of expiration of the Notification Period.

PLAN ADMINISTRATION

Responsibilities for Plan Administration

PLAN ADMINISTRATOR

Union County Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan) is the benefit plan of Union County, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Union County to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Union County shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR

- **A.** To administer the Plan in accordance with its terms.
- **B.** To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- **C.** To decide disputes, which may arise relative to a Plan Participant's rights.
- **D.** To prescribe procedures for filing a claim for benefits and to review claim denials.
- **E.** To keep and maintain the Plan documents and all other records pertaining to the Plan.
- **F.** To appoint a Claims Administrator to pay claims.
- **G.** To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION.

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- **A.** with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

B. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

A. the named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

B. the named fiduciary breached its fiduciary responsibility.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Retired Employee and Dependent Coverage: Funding is derived from the funds of the Employer and the contributions made by the covered Retired Employees. These Retired Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Retired Employee.

Benefits are paid directly from the Plan through the Claims Administrator.

Union County and covered Retired Employees share the cost of Retired Employee and Dependent coverage under the Plan.

The Union County Manager and Board of Commissioners set the level of any Retired Employee contributions of the Plan. The Board of County Commissioners reserves the right to change the level of Retired Employee contributions.

Health Reimbursement Account Funding (Traditional Option Only)

Union County makes an Annual Contribution that pays the full cost of Retired Employee and Dependent coverage under the Health Reimbursement Account portion of the Plan.

When an eligible Retired Employee becomes a Plan Participant in accordance with the provisions described above, Union County will establish a Health Reimbursement Account (HRA) for that Plan Participant to receive Health Reimbursement Benefits in the form of reimbursements for Medical Care Expenses, as described in the Health Reimbursement Benefits portion of the Plan. In no event will Health Reimbursement Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. Union County will make an Annual Allocation payable from Union County's general assets. This Annual Allocation is further described below in the Benefit Description for the Health Reimbursement Account. Nothing herein will be construed to require Union County or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Plan Participant, and no Plan Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of Union County from which any payment under this Plan may be made. There is no trust, or other fund from which Health Reimbursement Benefits are paid.

Union County funds the full amount of the HRA Accounts through an Annual Allocation. There are no Plan Participant contributions for Health Reimbursement Benefits under the Plan. Finally, under no circumstances will the Health Reimbursement Benefits be funded with salary reduction contributions, employer contributions (e.g. flex credits) or otherwise under a Section 125 Cafeteria Plan.

IMPORTANT

Union County's Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan) have been established within the meaning of Section 125 of the Internal Revenue Code of 1986 as amended. In exchange for the favorable tax treatment of contributions paid toward the cost of providing benefits, the Internal Revenue Service imposes specific requirements on Retired Employees' elections decisions. Enrolling on a pre-tax basis requires Retired Employees to adhere to the rules as explained in the Change in Family Status provisions.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS

All Plan Participants shall be entitled to:

A. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan.

B. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

C. Continue health care coverage for a Plan Participant, spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Retired Employees or Dependents may have to pay for such coverage.

D. Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

E. If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

F. In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Use and Disclosure of Protected Health Information

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the following provisions apply:

A. **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

B. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

C. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

D. **Updates Required.** The Employer shall amend this document promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

E. **Use and Disclosure Restricted**. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

F. **Resolution of Issues of Noncompliance**. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

a. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

b. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

c. Mitigating any harm caused by the breach, to the extent practicable; and

d. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

G. Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

d. Report to the Plan any use or disclosure of Protected Health Information of which it becomes aware inconsistent with the uses or disclosures permitted by this document, or required by law;

e. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

g. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

i. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

j. Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The Plan Sponsor shall only allow access to PHI to certain named employees, or classes of employees, or other persons under control of the Plan Sponsor who have been designated to carry out Plan Administration functions. A list of such employees will be made available upon request and free of charge. The access and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan. In the event any of the individuals described above do not comply with the provisions of the plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, suspension and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the *Plan Sponsor* agrees to:

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

- Report to the *Plan* any Security Incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

BREACH OF PRIVACY OR SECURITY STANDARDS

Agents and "business associates" of the Plan are required to notify and report to the Plan any use or disclosure of PHI not permitted by HIPAA which compromises the privacy or security of PHI. Such notice will be made following discovery and without unreasonable delay, but in no event later than sixty (60) calendar days following discovery of a "breach" of "unsecured protected health information".

- "*Business associate*" shall mean a person who performs functions or activities on behalf of, or certain services for, a Plan that involve the use or disclosure of protected health information. A *business associate* is also:
    - A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the business associate;
    - A Patient Safety Organization;
    - A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires routine access to such protected health information; and
    - A person who offers a personal health record to one or more individuals on behalf of a covered entity.
- "*Subcontractor*" shall mean a person who acts on behalf of a *business associate* other than in the capacity of a member of the workforce of such *business associate* has delegated a function, activity, or service that the *business associate* has agreed to perform for a covered entity or *business associate*. A *subcontractor* is then a *business associate* where that function, activity, or service involves the creation, receipt, maintenance, or transmission of protected health information.
- "*Breach*" shall mean an impermissible use or disclosure of unsecured protected health information which comprises the security or privacy of such information unless the covered entity or *business associate*, as

applicable, demonstrates that there is a low probability that the protected health information has been compromised. "*Breach*" does not include:

- Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a Plan or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under HIPAA.
- Any inadvertent disclosure by a person who is authorized to access PHI for this Plan or a business associate to another person authorized to access PHI for the Plan or business associate, or organized health care arrangement in which the Plan participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
- *"Unsecured protected health information"* shall mean PHI that is not secured through the use of technology or methodology specified by the Secretary of the Department of Health and Human Services ("DHHS") that renders PHI unusable, unreadable or indecipherable to unauthorized individuals.

Any terms not otherwise defined in this section shall have the meanings set forth in the privacy standards and the security standards.

Agents and business associates shall cooperate with the Plan in investigating any breach and in meeting the Plan's obligations to you and DHHS and any other security breach notification laws.

The Plan will notify you (in the manner required by law) of any use or disclosure (in the manner required by law) of any use of disclosure of PHI not permitted by HIPAA which compromises the privacy or security of PHI. If your unsecured protected health information has been, or is reasonably believed by the Plan, to have been accessed, acquired, or disclosed during a breach, you will be notified, including:

A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

- A description of the types of unsecured protected health information that were involved in the breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
- Any steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of what the Plan involved is doing to investigate the breach, to mitigate harm to individuals, and to protect against any further breaches; and
- Contract procedures for you to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, Web site, or postal address.

Notice of a discovery of a breach by a business associate to the Plan shall include:

- The identification, to the extent possible, of each individual whose unsecured protected health information has been, or is reasonably believed to have been, acquired, used , or disclosed during the breach; and
- Any other available information that the Plan is required to include in the notification to you, as described above, at the time notification is required or as promptly thereafter as information becomes available.

The Plan has the right to terminate any contact with any agents and business associates, if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of agents and business associates, or the Plan's respective obligations regarding PHI, and, on notice of such material breach or violation from the Plan, fails to take reasonable steps to cure the material breach or violation.

Effective with the required compliance date of any regulation or amendment to a regulation promulgated by DHHS that affects the Plan's obligations with respect to the use or disclosure of PHI, this Plan will automatically amend so that such obligations imposed on the Plan are in compliance with the regulation or amendment to the regulation. This Plan will at all times comply with the HIPAA privacy standards and security standards.

Genetic Information Nondiscrimination Act of 2008 ("GINA")

What is "genetic information" under GINA?

Under GINA, the term "genetic information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. The manifestation of a disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are dependents, as well as any other first, second, third or fourth degree relative. Further, genetic information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic information does not include the sex or age of an individual.

GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of "genetic information".
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study so long as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing genetic information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, application of any pre-existing condition exclusion under the Plan, and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing genetic information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains genetic information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA so long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

BY THIS AGREEMENT, the Union County Group Health Insurance Program for Retirees (Retired Employee Health Plan, Health Reimbursement Account and Major Medical Plan), is hereby adopted as shown:

IN WITNESS WHEREOF, this instrument is executed for Union County on or as of the day and year first below written.

By Julie Broome
Union County

Date 6-21-2019

Witness Dorothy G Rabbin

Date 06/21/2019

END OF DOCUMENT