

**Summary Plan  
Description  
of the  
Defined Benefit  
Self-Funded Health  
Care Plan**

**of  
XYZ Company**

**Effective July 1, \_\_\_\_\_**

# Schedule of Benefits

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# STATEMENT OF ERISA RIGHTS

## Help Control Health Care Costs-Stay Fit!!

With the aging of America, more and more people are taking the fitness trail to better health resulting in longer, healthier and happier lives. Lower health care costs result when prevention is practiced through staying well.

Just a few suggestions:

- Say no to drugs and tobacco; also to alcohol, except in moderation. Watch your weight. Eat three (3) nutritious meals a day, starting with breakfast.
- Avoid junk food, sugar, salt and fatty foods as much as possible.
- Exercise to relieve tension and improve appearance; also to increase coordination, endurance, respiration and circulation.
- Take safety precautions at home and on the road. Don't forget to buckle up.
- Seek early treatment if any health problem develops.

## Special Alerts to Covered Persons

Written proof of loss because of injury or illness must be furnished to the Plan Supervisor within the Claim Filing Period stated in the Schedule of Benefits. Such prompt action will prevent providers sending nonpayment reminder notices. Most important-claims not furnished within the Claim Filing Period will not be paid unless it was not reasonably possible to furnish proof within this time. Fraud or Deceit-Any intentional misstatement of material and relevant facts by, or on behalf of, a participant may result in enrollment being voided and/or denial of benefits.

Several important features of this Plan must be noted:

Plan benefits are self-funded which means that the Employer has the ultimate responsibility for providing the benefits.

The Plan has certain cost containment provisions which may result in reduced benefits. See Cost Containment Provisions.

The Plan's benefits, including the determination of reasonable and customary charges, are paid using the Benefit Processing Guide shown in the Schedule of Benefits.

## Summary Plan Description-Plan Document Disclaimer

This booklet is a summary, briefly describing the benefits and provisions of your health care plan. The Plan Document will determine all of your rights and benefits. This Summary Plan Description is not a contract. Should there be any discrepancy between this Summary Plan Description and the Plan Document, the Plan Document will govern.

The Plan Document is long and complicated; it is not possible to create a perfect summary as mandated by ERISA; to reproduce the entire Plan Document as the Summary Plan Description would violate both the letter and spirit of ERISA. With this Summary Plan Description the Schedule of Benefits is a perfect replica of the Plan Document Schedule of Benefits. The text portion of such descriptions is a summary of such Document.

You may view the Plan Document in its entirety any of these ways:

- Visual inspection of your employer's copy.
- Request copies of any and all of the pages of such document by paying copying charges.
- Bring Plan Document up on the Internet at \_\_\_\_\_.  
Such is \_\_\_\_\_ text only \_\_\_\_\_ full Plan Document (Schedule of Benefits plus Attachments).

## Certain ERISA Requirements

This Summary Plan Description has been prepared to furnish you, the Participant, with information regarding the benefits to which you and your eligible dependents may be entitled under this Plan. The Employee Retirement Income Security Act of 1974 (ERISA) requires that all Participants be furnished a Summary Plan Description (SPD/Booklet) of their benefit plan.

The Schedule of Benefits in this booklet gives you this information and details about the benefits of your Plan. The objective of this booklet is to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of the Summary Plan Description, please consult your Plan Supervisor.

The Schedule of Benefits identifies the Plan name, Effective Date of the Plan, Type of Welfare Plan, Plan Year, the Plan Administrator, the Plan Supervisor, the Plan Trustees, if any, the Plan Coordinator and the required Plan Numbers. The Employer shown in the Benefit Schedule is also the Plan Sponsor, Benefits on behalf of named Participating Employers may also be provided through the Plan.

## Statement of Rights

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

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, if such report is required.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 Series), if required, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report, if the plan is required to prepare such a report. Some plans, such as plans with fewer than one hundred (100) participants, may not be required to prepare a summary annual report.
- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan and the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting condition under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a

welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within thirty (30) days, you may file suit in a Federal Court. In such a case, the Court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay Court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## **Appealing an Unreimbursed Claim and Appealing a Determination of Prior Creditable Coverage**

If your claim should be denied in whole or in part, you will receive written notification delivered in the same fashion as a reimbursement of a claim. A claim worksheet or Explanation of Benefit (EOB) will be provided by the Plan Supervisor showing the calculation of the total amount payable, charges not payable, and the reason. If you do not understand the reason for any unreimbursed amount or disagree with the adjudication, call the Plan Supervisor.

If your claim should be denied and the benefit is significant, you will be given a written formal denial letter stating clearly and precisely why the claim was denied and action that may be taken on your part to have the claim reviewed for possible payment. If you believe the claim was denied in error, you should respond to the formal denial letter with a request for a review by the Plan Supervisor.

Upon this written request, which must be filed within sixty (60) days after the denial, the Plan Supervisor will review the claim in question and give a written decision of the review within sixty (60) days after such request is received [or within one hundred twenty (120) days under special circumstances]. You may also use this procedure to appeal any determination that has been made under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding your prior creditable coverage. Legal action against the Plan is possible; however, it must be filed during a given period. That period is from sixty (60) days to three (3) years from date proof of loss is filed. You should not file legal action against your Plan until you have gone through the appeal procedure described above.

## Other Items of Interest

You receive no special employment rights from this Plan. The Employer shall have the sole and final authority to control, manage and determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The named Plan Administrator may delegate responsibilities for the operation and administration of the Plan to the Plan Supervisor. The Plan Administrator shall nominate a person or persons, referred to in the Schedule of Benefits as the *Plan Coordinator* to assist in day-to-day Plan matters. The Plan Administrator shall have the authority to amend the Plan and to determine its policies, to appoint Plan Supervisors, fix their compensation (if any), and exercise general administrative authority over them. Copies of amendment for any material reduction in covered services or benefits will be furnished to the Plan Participants no later than sixty (60) days after the adoption of the changes. The Plan Administrator has the sole authority and responsibility to review and make final decision of Plan matters such as benefit adjudication, eligibility for coverage determination and construing terms. Further, the Plan Administrator will, in its sole discretion, have complete authority to determine the validity and acceptability of Certificates of Creditable Coverage.

All Certificates of Creditable Coverage accepted by the Plan Administrator will be honored by this Plan for the purpose of satisfying this Plan's Preexisting Condition provisions, provided however that a Certificate of Creditable Coverage which is subsequently determined to be inaccurate, erroneous or fraudulently obtained or prepared shall be disregarded.

The Plan Administrator shall, in its sole discretion, interpret all Plan provisions, and make all determinations as to whether any particular Covered Person is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. If any eligible employee who performs services for this Employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such an employee shall be treated as agreeing with and consenting to any decisions that the Plan Administrator makes, in its sole discretion, and further agrees to the limited standard of review described by this section by acceptance of such benefits.

While the Plan is intended to be permanent, it may be amended or terminated by the Employer at any time as it deems it to be prudent. Any Plan Amendment shall be written, and shall indicate both the effective date of the change and the execution date of the amendment. You will be furnished a copy of the amendment. Plan benefits are legally enforceable. The Plan is maintained for the exclusive benefits of the participants.

Overpayments, made in error, are recoverable by the Plan. Under facility of payment rules, payments may be made to persons to expedite payments and satisfy Plan liabilities. Plan liabilities will cease after a period of one year from the payment due date if persons are not found who are to receive such payments or if the benefit checks are not cashed.

Plan benefits are not subject to anticipation, sale, pledge or attachment or similar alienation. You always have the right of free choice of doctor and hospital. Your workers' compensation benefits are not affected by your Plan. Unless otherwise provided, coverage is not extended to retired or former Plan participants. Benefits, participation or other requirements mandated by federal law or regulations will be provided by your Plan. Where misstatements occur, benefits or eligibility, incorrectly determined, will be redetermined using the correct information.

## **Some Important Do's and Don'ts**

There are many "do's" and "don'ts" which you should keep in mind. These simple rules will make your Plan run smoothly.

- Do be sure your enrollment form is filled in accurately, completely, legibility, and timely.
- Do notify your Plan Coordinator of any changes in name, address, dependent status, beneficiary, etc.
- Do prepare the claim form completely and accurately using the form obtained from the Plan Coordinator.
- Don't submit duplicate bills; do include the physician's statement (with diagnosis shown) and the hospital statement. Do send drug receipts with Rx Number-actual bills are needed.
- Don't send canceled checks or cash register receipts.
- Don't wait until the end of the Benefit Year to send in expenses. Do send them in as you receive them.
- Do file your claim within the Claim Filing Period as stated in the Schedule of Benefits.
- Do contact the Plan Supervisor if you have any questions. The Plan Supervisor, more than the Plan Coordinator, will be able to assist you.
- Do use an a claim form when:
  1. Claim involves an accident.
  2. Patient is a dependent over the age as stated in the Schedule of Benefits.
  3. Other coverage including Medicare has been added or dropped.
- Do allow six (6) weeks for payment of a claim from the date you mailed the claim. Don't call for status before the end of such six (6) week period.

## **Some Important Do's and Don'ts (Continued)**

- Don't send bills without showing your name, your Employer name and the Plan number. If your physician or hospital accepts an assignment, be certain that they know the name of your Employer.
- Do expect the Plan Supervisor to require certain items such as your current address, all details of an accident, and information about any other medical coverage which you or your dependents may have, including Medicare.
- Do contact the Plan Supervisor prior to any organ transplant surgery.

# MISCELLANEOUS

## Filing a Claim

1. Claims and bills will usually be submitted to the Plan Supervisor directly by your medical Provider.
2. In some instances, you will be required to file a claim form with the Plan Supervisor. When this becomes necessary, your Plan Coordinator will give you an appropriate claim form.
3. Send the claim form or forms to the Plan Supervisor within the Claim Filing Period as stated in the Schedule of Benefits. Failure to do so may result in the Plan Supervisor denying your claim. Such denial may be reversed if circumstances made such delay justified.
4. After claims are submitted and determined to be payable, the Plan Supervisor will process and pay your claims within thirty days of their approval. However, if there is to be a delay in paying such claims, the beneficiary will be given a written notice explaining this delay. Claim forms are available from your Plan Coordinator or the Plan Supervisor. As an administrative convenience, the Employer may request you notify the Plan Supervisor directly and that you deal directly with them rather than with the Plan Coordinator. Benefits may be assigned at your request.
5. If your Plan does not include a Prescription Drug Card, you may submit prescription receipts and any other small bills directly to the Plan Supervisor.

If the Plan Administrator or its representatives request pertinent information from a participant or dependent to investigate or process a claim submitted within the Claim Filing Period, and such pertinent information is not provided as provided in the Appendix-Claims Procedures immediately following the date of the initial request for information, then no benefit, or no further benefits, hereunder as the case may be, shall be payable for such claim(s). The Plan Administrator may waive this provision if, in its sole discretion, it is shown that the pertinent information requested was not provided due to mental or physical incapacity of the participant or due to some other intervening factor that reasonable excuses timely submission of the requested material or information. The Plan Administrator shall, in its sole discretion, determine what constitutes pertinent information and what constitutes an acceptable reason justifying a delay in submission of requested material or information.

## Plan Funding

The Schedule of Benefits indicates how Plan benefits are funded, if contributions from you are required, or if the Plan uses a trust.

## When Are You and Your Dependents Eligible?

The Schedule of Benefits lists which Employees or Employee classes are eligible for coverage, the Eligibility Waiting Period, the Qualifying Hours you must work during the Eligibility Waiting Period, and the Minimum Hours per week you must work to be considered Actively-at-Work.

**If your Plan has a re-employment period, as indicated in the Schedule of Benefits:** The Eligibility Waiting Period is waived if you are rehired within the Re-Employment Period, if any, shown in the Schedule of Benefits; if you were covered under COBRA during the period between your termination and being rehired, coverage is effective on the day you are rehired; if you were not covered under COBRA during this period, coverage is effective the first day of the month following Re-Employment.

If you were covered by the previous Employer plan, upon timely completion of an enrollment form, you are automatically covered under this Plan.

As a new employee of an Eligible Class, as shown in the Schedule of Benefits, upon timely completion of an enrollment form, your coverage will begin at the end of the Eligibility Waiting Period.

You must complete an enrollment form within the following time period to be covered:

- Contributory health (where you are required to pay for coverage) – within thirty (30) days of becoming eligible.
- Non-contributory health (where you are not required to pay for coverage) – within one hundred eighty (180) days of becoming eligible. This 180 day provision applies only to you.

If you do not apply when first eligible, you may apply for coverage at a later date if (a) you satisfy the Special Enrollment Rules of this Plan; (b) this Plan offers an Open Enrollment or; (c) if this Plan permits Late Enrollment. If you fail to apply for coverage on a timely basis, you will be a *Late Enrollee*. Your dependents become eligible for coverage when you do. If any dependent is not enrolled when first eligible, the same rules about applying for coverage at a later date apply.

Coverage for newly acquired dependents is not automatic; they must be timely enrolled under the Special Enrollment Rules for coverage to be effective as a Special Enrollee. To timely enroll new dependents, you must apply within thirty (30) days of the date of eligibility (date of marriage, date of birth, date of adoption, date child is placed for adoption, or date of custody of a foster child). Such thirty (30) day period is extended to one hundred eighty (180) days for a dependent child or spouse in cases in which the addition of such dependent does not affect the employee's contribution to the Plan. (For example, if the Plan does not require any employee contribution or if the employee is already paying for family coverage). If coverage for a dependent is applied for more than thirty (30) days (or more than one hundred eighty (180) days where the employee's contribution does not change) following the date of such dependent's eligibility for coverage, the dependent will be a *Late Enrollee*.

Becoming covered and being fully protected are not necessarily the same. You may be a Participant in the Plan with limited coverage as explained in the preexisting conditions section.

Your Plan will provide coverage for any of your dependent children for whom there is a Qualified Medical Child Support Order, or other Court Order, as mandated by federal statutes. The Plan Sponsor determines whether the employee/parent must also enroll in the Plan when a Qualified Medical Child Support Order is in effect. The effective date of coverage for a Qualified Medical Child Support Order participant is the date that all the necessary documentation is received and processed by the Plan Supervisor or the initial effective date of the employee/parent, whichever occurs later. Even if the Plan does not require the employee/parent to be a Plan Participant, the eligibility of the Qualified Medical Child Support Order participant terminates when the employee/parent terminates employment with the Plan sponsor. A copy of the Plan's procedures for processing Qualified Medical Child Support Orders may be obtained from the Plan Administrator at no charge. Also, coverage for your adopted child or child placed for adoption may be provided on the date of adoption or the date of placement for adoption. Coverage for a foster child may be effective on the first day of the first calendar month beginning after the date sufficient evidence (as determined by the Plan Administrator or the Plan Supervisor) has been received demonstrating that the child is an eligible dependent, but no earlier than the date you obtained custody of the child. Application for such coverage must be timely and properly made.

## Special Enrollment Rules

**For Individuals Losing Other Coverage**-If you declined enrollment (coverage) for yourself or your eligible dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and your dependents in this Plan, provided you request enrollment (coverage) within thirty (30) days after the other coverage ends. **Each** of the following conditions must be met:

1. You or your eligible 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 and such coverage was (a) under a COBRA continuation provision and the coverage under such provision was *exhausted*, or (b) not under a COBRA continuation provision and either the coverage was terminated as a result of (i) *loss of eligibility* for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any *loss of eligibility* after a period that is measured by reference to any of the foregoing. Thus, for example, if your coverage terminates following a termination of employment and you are eligible for but fail to elect COBRA continuation coverage, this is treated as a *loss of eligibility*), or (ii) employer contributions towards such coverage were terminated.

*Loss of Eligibility* does not include a loss due to failure of the individual (employee or dependent) to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). *Loss of Eligibility* also means any other event as determined by the Plan Administrator.

Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

2. You provided a written statement at the time coverage was previously offered under this Plan that coverage under a group health plan or health insurance coverage was the reason for declining coverage. **(This means that if you do elect coverage under this Plan and later drop coverage for any reason, you will not be allowed to enroll in this Plan again unless the Plan allows Late Enrollment, has as Open Enrollment Period or allows re-enrollment. See the Schedule of Benefits).**
3. You apply for coverage no later than thirty (30) days after the date of (a) *exhaustion* of COBRA coverage, or (b) termination of coverage due to *loss of eligibility* for the coverage, or (c) termination of employer contributions towards such coverage.

(*Exhaustion* of COBRA continuation coverage means that an individual's COBRA continuation coverage ceases for any reason other than either (i) failure of the individual to pay premiums on a timely basis, or (ii) for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have *exhausted* COBRA continuation coverage if such coverage ceases (a) due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or (b) when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual).

The effective date of coverage for these *Special Enrollees* shall be the first day of the next calendar month following application.

**For Newly Acquired Dependents**-If you have a new dependent as a result of marriage, birth, adoption, placement for adoption or obtaining custody of a foster child, you may enroll yourself, if not already a Participant, your spouse and your new dependent child(ren), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, placement for adoption or obtaining custody of the foster child.

The effective date of coverage for your spouse and any such newly acquired dependent child(ren) who are properly enrolled shall be the date of the marriage, birth, adoption or placement for adoption. The effective date of coverage for your spouse and your foster child shall be the first day of the month following the date that sufficient evidence has been received to determine that the child is an eligible dependent, but no earlier than the date the Participant obtained custody of the child. In any case, the effective date of coverage shall not be earlier than the date the Participant would be eligible for coverage, according to the Schedule of Benefits.

If coverage for an individual is applied for more than thirty (30) days following the date the individual became eligible under these **Special Enrollment Rules**, the individual will be considered a *Late Enrollee*. If this Plan allows *Late Enrollment*, such *Late Enrollees* will be subject to a post-coverage waiting period of eighteen (18) months for preexisting conditions. See the Schedule of Benefits to determine if this Plan allows *Late Enrollment*.

An individual who is enrolled under the plan according to the Plan Document's Open Enrollment provision, if any, is not a *Late Enrollee*.

## When Does Coverage Terminate?

Your coverage terminates when any of the following occurs: when the Employer terminates the Plan; when your employment is terminated for any reason; when you change to an employee class not covered; when you fail to meet the actively-at-work requirements (except for extension of benefits coverage); or when you fail to make a required contribution to the Plan.

The Plan may provide for extended coverage while you are on an Employer-approved leave-of-absence or while you are disabled.

**Please Note:** The Schedule of Benefits has details on leave and disability extensions.

**See:** Important sections on Continuation (COBRA Benefits), conversion of medical benefits, and extension of coverage.

## Who May Be A Dependent?

Your spouse (if not legally separated) and your unmarried children may be dependents. A child must be a minor or a full-time student in an accredited school, college or university (unless being a student is not required in the Schedule of Benefits), and must be principally dependent upon the participant for financial support. A child will be presumed to be a dependent if such child is claimed as a dependent for federal income tax purposes. Regardless of age, a physically handicapped or mentally retarded child may be a dependent if satisfactory proof of condition is provided and approved by the Plan Supervisor and if so indicated in the Schedule of Benefits.

The Schedule of Benefits shows the ages to be considered a minor or a student (if being a student is required). Your adopted child, child placed for adoption, step or foster child may be covered if financially dependent on you as evidenced by appropriate documentation as required by the Plan Supervisor.

Dependent status, once lost, may be reacquired in the following manner: for dependent children who are not covered by the Plan because either:

- a) they were previously covered under the Plan and lost coverage because they exceeded the eligibility age and did not remain in school; or
- b) they were already over the eligibility age when coverage was first available;

such dependent children may become covered under the Plan if they become full time students before reaching the extended eligibility age set out in the Schedule of Benefits (if the Plan provides for an extended eligibility age). The effective date of coverage for any such dependent child who reacquires dependent status while covered as a COBRA participant as a result of losing coverage under this Plan due to exceeding the eligibility age shall be the first day they become full time students. The effective date of coverage for any such dependents who reacquire dependent status but are not covered under COBRA with this Plan shall be the first day of the month after the day they become full-time students.

In those situations where a Dependent Child was not enrolled when first eligible, is now over the Unmarried Child's Eligibility Age but is still younger than the extended eligibility age (if any) provided in the Schedule of Benefits, such child may be enrolled in the Plan if he or she becomes a full time student and if the Plan allows Late Enrollment. Likewise, a Dependent Spouse who lost coverage under the Plan due to legal separation but has now reconciled with his or her employee spouse may re-enroll in the Plan if the Plan allows Late Enrollment.

# HEALTH CARE BENEFITS

## What Are The Plan Benefits?

Your Plan provides the following benefits:

1. You must first meet your Deductibles.
2. Then Covered Expenses are paid at the Plan's Copayment Rate until the Out-of-Pocket Maximum is met, after which the rate is 100%.
3. There is an overall Lifetime Maximum Benefit as well as special maximum benefit limitations such as for mental and nervous disorders.
4. There are numerous Limitations and Exclusions.
5. Some charges are not treated as Covered Expenses.
6. Some Hospital and Medical Care may be excluded or paid at reduced rates.
7. Some selected charges may be covered without regard to the Deductible and/or the Copayment Rate.
8. Special rules may apply to Convalescent Care, Home Health Care, Hospice Care, and Maternity Benefits.
9. Benefits may be reduced because of the Coordination of Benefits with other plans including automobile medical and no-fault benefits. Also, the Plan has subrogation rights.
10. Benefits may be paid even if you are not actively-at-work under Extension, Continuation, and Conversion Benefits.

Deductibles and out-of-pocket limits are determined each Benefit Year. Consult the Schedule of Benefits and Booklet for details on each of the ten items shown above.

The Schedule of Benefits sets forth the Deductible Amount, Copayment Rate, Maximum Amounts, Mental and Nervous Benefits and Limitations, Out-of-Pocket Expenses, first dollar benefits (those not subject to deductible and copayments), and those expenses which are covered. The deductible and out-of-pocket amounts are determined by the **Benefit Year** as set forth in the Schedule of Benefits.

## How Does The Deductible Amount Work?

The first dollars of Covered Expenses that Covered Persons must pay are called Individual Deductibles and Special Deductibles and are set forth in the Schedule of Benefits.

- If each family member had to meet this deductible, a large family might be hurt financially which is the reason for the Maximum Deductible Per Family, if any, in the Schedule of Benefits.
- Deductibles may be waived for accidents or modified for a common accident involving family members. There may be special deductibles which apply to hospitalizations, physician visits, emergency room visits, prescriptions, etc.

If the deductible is not reached during the Benefit year, any amount incurred and accumulated during the last three years (3) months of that period may be applied toward the next benefit period's deductible requirement, if so indicated under Deductible Carryover Period in the Schedule of Benefits. See the Schedule of Benefits for details on Deductibles.

## What Is The Benefit Formula?

After you meet your deductible, the Plan Copayment Rate is applied to your Covered Expenses. If the Plan Copayment Rate was applied to each family member, substantial Out-of-Pocket Expenses could be incurred by large families. To prevent this, a family Out-of-Pocket Maximum may apply.

Certain Covered Expenses, reduced by a special copayment rate (mental and nervous, for example), may not count toward the Out-of-Pocket Maximum. The Plan Copayment Rate is 100% after the Out-of-Pocket Maximum has been met. See the Schedule of Benefits for more details.

## What Are The Maximum Plan Benefits?

You and each of your dependents have an Individual Lifetime Maximum Benefit as set out in the Schedule of Benefits. As you use your Plan and receive benefits, these benefits count against your maximum. The Schedule of Benefits indicates whether benefits received by you from previous Employer-sponsored medical plans count towards this maximum. Some of the lifetime maximum may be restored in certain circumstances if your Plan allows a benefit restoration. The Schedule of Benefits sets forth your Individual Lifetime Maximum and your Annual benefit Restoration, if any.

## What Are Covered Expenses?

Generally, a hospital-medical-surgical charge becomes a Covered Expense if it is administered, supervised or ordered by a physician; medically necessary; not experimental or custodial; not otherwise excluded; and is usual, reasonable and customary in both amount and medical practice. Following is a list of Covered Expenses-not necessarily a complete listing:

- Hospital room and board. If the hospital has only private rooms, covered expenses will be paid as shown in the Schedule of Benefits.
- Intensive care (may be subject to a limitation). See Schedule of Benefits.
- Hospital special purpose rooms and miscellaneous charges (including therapies, laboratory, and radiology).
- Anesthesiology charges. See Schedule of Benefits.
- Surgical procedures. See Schedule of Benefits. This includes medical and surgical benefits with respect to a mastectomy to provide the following coverage to a covered person who currently is receiving Plan benefits for a mastectomy and who elects breast reconstruction in connection with such mastectomy: 1) reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce symmetrical appearance; and 3) coverage for prostheses and physical complication of all stages of mastectomy, including lymphedemas; in a manner determine in consultation with the attending physician and the patient. Self funded state and local government plans may opt-out of this coverage by filing the appropriate election with the Health Care Financing Administration. See you Plan Coordinator for details.
- Convalescent, home, and hospice care. See Schedule of Benefits.
- Ambulance (area or local only).
- Diagnostic (e.g., radiology, sonography, pathology, cardiology, gastroenterology or laboratory).
- Radiation therapy or chemotherapy.
- Prescription drugs. See Schedule of Benefits.
- Charges for required in-hospital nursing.
- Administration and processing of blood.
- Administration of gas and oxygen.

## What Are Covered Expenses? (continued)

- Necessary medical supplies (such as dressings, stitches, casts, splints, trusses, braces, etc.).
- Rental of durable equipment (such as beds, wheelchairs, etc.).
- Cost of artificial eyes, limbs, etc. (not replacement).
- Voluntary sterilization (not the reversal procedure).

## What Are the Limitations and Exclusions?

These limitations and exclusions always apply **unless otherwise modified in the Schedule of Benefits**-*not necessarily a complete listing*:

1. For charges incurred in connection with the care or treatment of any sickness contracted or injury sustained subsequent to the effective date of the Plan which result from war, declared or undeclared, or any act of war, invasion, hostilities, riot, rebellion, insurrection or aggression.
2. For charges incurred in connection with eye refractions or the purchase or fitting of eyeglasses or hearing aids except as may otherwise be provided under *Vision Care Benefits* or *Hearing Care Benefits*, as set forth in the Schedule of Benefits.
3. Charges incurred in connection with cosmetic surgery except to correct a condition resulting from a non-occupational traumatic injury, and when the charges are incurred within two (2) years of said traumatic injury; or except when medically necessary to correct a congenital anomaly of a dependent child; or except to correct a symmetry disparity condition within two (2) years following breast reconstruction surgery due to a mastectomy. Coverage for any of the listed exceptions to the cosmetic surgery exclusion are subject to any applicable preexisting condition post coverage waiting periods.
4. For charges incurred for routine health checkups, and pediatric care.
5. For charges incurred in connection with or resulting from drug addiction and alcoholism.
6. For charges incurred for any intentionally self-inflicted injury or sickness, including suicide or attempt threat.

## What Are the Limitations and Exclusions? (continued)

7. For charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be paid for charges incurred for dental treatment required because of (a) injury to natural teeth due to an accident when said accident occurred within one year prior to said treatment or (b) dental treatment required because of medical care (such as x-ray treatment for oral cancer or chemotherapy) (this shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture) except as otherwise provided under *Dental Benefits* as set forth in the Schedule of Benefits.
8. For charges incurred for services or supplies which are furnished, paid for or otherwise provided for by reason of the past or present services of any person in the armed forces of a government.
9. For charges incurred for nursing except for the services of a Registered Nurse or Licensed Practical Nurse, as may be required by a physician as necessary to safeguard any Covered Person's life.
10. For charges incurred for services and supplies which are not medically necessary for treatment of the injury or sickness or are not recommended and approved by the attending physician, or charges to the extent that they are unreasonable.
11. For charges incurred for services or supplies which constitute personal comfort or beautification items. For charges for sex transformations and studies or treatment related thereto, sexual dysfunction or inadequacy which include, but are not limited to, implants and related hormone treatment.
12. For charges incurred for hospitalization primarily for x-ray, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an actual sickness or injury.
13. For charges for expenses in connection with either of the following:
  - (a) any condition for which a Covered Person has received or is entitled to receive, whether by settlement or by adjudication, any benefit under Workers' Compensation or Occupational Disease Law or similar law.
  - (b) Any occupational-related injury or sickness.
14. For charges that would not have been made if no coverage existed or charges that a Covered Person is not required to pay.
15. For charges for any resident or intern of a hospital.
16. For charges incurred prior to the date coverage is effective under the Plan or after coverage is terminated.

## What Are the Limitations and Exclusions? (continued)

17. For charges incurred for sickness or injury suffered in connection with or arising from the commission or attempted commission by the Covered Person of a felony or an assault or battery. This exclusion does not apply to the victim(s) of such act.
18. For charges incurred for the replacement of an initial prosthesis, unless the replacement is necessitated by the natural growth or pathological changes of the affected site.
19. For charges incurred for injuries sustained as the result of an illegal controlled substance.
20. For the difference between the usual, customary and reasonable charges and the actual charges of a physician or hospital.
21. For charges for routine foot care, treatment for flat feet, treatment for subluxation of foot, cutting or removal of corns and calluses, trimming of nails and corrective shoes. Charges for medically necessary care and emergency or corrective foot surgery, however, will be considered to be covered expenses.
22. For charges for immunization for the prevention of contagious disease.
23. For charges for custodial or domiciliary care, for rest cures, or for weight reduction.
24. For charges for the services of any person who is a member of the participant's immediate family or who ordinarily resides in the participant's home.
25. For charges incurred in connection with any operation or treatment for realignment of teeth or jaws, including, but not limited to, atrophy of the lower jaw, occlusion, maxillofacial surgery, temporomandibular joint dysfunction and retrognathia unless otherwise provided in the Schedule of Benefits. This exclusion shall not be construed to deny otherwise eligible expenses for the treatment of the teeth or jaws when such treatment is necessitated by traumatic injury that occurred within one year prior to the treatment.
26. For charges for elective surgery.
27. For charges for exogenous obesity, including any prescription drugs, surgery or other treatment, except when established to be medically necessary.
28. For illness or injury caused by or arising out of atomic explosions or nuclear energy, whether or not the result of war.
29. For charges for artificial insemination or invitro fertilization; for charges for all medical care and treatment and prescriptions for infertility.
30. For charges for treatment of developmental disorders.

## What Are the Limitations and Exclusions? (continued)

31. For charges for medical or hospital services, medical or hospital supplies, or prescription drugs for a Covered Person incurred in a foreign country where the primary purpose of such foreign travel was to obtain such medical care or hospital care.
32. For expenses for experimental or investigative drugs, devices, medical treatment, or procedures. This exclusion will not be construed to deny otherwise eligible expenses for medically necessary treatment of breast cancer by high-dose chemotherapy in conjunction with an autologous or allogenic bone marrow transplant or peripheral stem cell transfusion.
33. For charges for treatment of a preexisting condition as defined in this Plan Document, subject to specification in the Schedule of Benefits.
34. For implanted devices for control of pain in excess of one (1) device, internal battery replacement and/or implantation per Benefit Year.
35. For charges incurred for a penile implant unless otherwise provided for in the Schedule of Benefits.

## What Charges May Be Reduced Or Eliminated?

- Hospital room and board charges are normally paid at the average semi-private rate of the particular hospital as set forth in the Schedule of Benefits.
- Hospital intensive care charges may be limited to a multiple of the average semi-private room rate such as two (2) or three (3) times as set forth in the Schedule of Benefits.
- Mental and nervous disorders normally may be limited in several ways as set forth in the Schedule of Benefits:
  - a. Inpatient care.
  - b. Copayment rate for outpatient as well as the per diem outpatient.
  - c. An overall lifetime maximum or annual maximum may apply to each individual for mental and nervous disorders.
  - d. Benefits for chemical dependency may be treated as a mental and nervous disorder, paid as a special chemical dependency benefit or no coverage provided as set forth in the Schedule of Benefits. Contact your Plan Administrator for a definition of mental and nervous disorders.
- Physician and surgical benefits may be limited by the usual, reasonable and customary charges as set forth in the Schedule of Benefits.
- Cost Containment Reductions-Certain Covered Expenses may be reduced if required cost containment rules are not followed as set forth in the Schedule of Benefits. Also, certain covered expenses may not be covered as specified in the Schedule of Benefits.

## Are Some Expenses Paid In Full?

The Schedule of Benefits will state whether or not some expenses may be paid in full, that is, not subject to either the Deductible or the Copayment Rate. For such expenses that are paid in full, there usually will be a dollar limit or maximum as set forth in the Schedule of Benefits. The following are expenses which may be paid in full:

- Supplemental Accident-The deductible may be waived or some accident benefits may be paid at 100% as set forth in the Schedule of Benefits. Charges must be incurred within ninety (90) days of the accident.
- Outpatient Surgery Benefits-May be paid in full if specified in the Schedule of Benefits.
- Pre-Admission Testing Benefits-May be paid in full if specified in the Schedule of Benefits.
- Second Surgical Opinion-A maximum limit for the second opinion may apply as set forth in the Schedule of Benefits. Also, such opinions may be optional or mandatory as set forth in the Schedule of Benefits. In addition, charges may be reduced where a second opinion was required and not obtained as shown as the second opinion penalty in the Schedule of Benefits.

## What Special Benefits Are Provided?

The Plan may provide certain benefits which may require special attention.

1. **Maternity**-Pregnancy will be treated as any other illness, and is not subject to any preexisting condition limitations, but pregnancy benefits are available only to participants and spouses who are provided dependent coverage. Routine nursery care (well baby care) and birthing center care may be covered as set forth in the Schedule of Benefits. With respect to an adopted child, or a child placed for adoption, no maternity expenses associated with the birth of such a child will be covered under this Plan unless the birth mother is a covered Participant or a covered dependent spouse or a covered dependent if coverage for dependents is specifically set out in the Schedule of Benefits.

This Plan contains no limitation or incentive to reduce coverage for a hospital stay to less than forty-eight (48) hours immediately following a normal vaginal delivery, or to less than ninety-six (96) hours immediately following a cesarean section for both the mother and the newborn child.

## What Special Benefits Are Provided? (continued)

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay up to forty-eight (48) hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

2. ***Convalescent Care***-You and your covered dependents may receive convalescent care benefits, as stated in the Schedule of Benefits. Such care is recovery-type care from an accident or illness in a facility which is very much like a regular hospital. This care does not include a rest facility, a facility for the aged, or one used principally for alcohol or drug abuse. The care must commence shortly after a period of hospitalization and is limited to a definite period of convalescence. These limitations are stated in the Schedule of Benefits. Convalescent care is not provided for drug and alcohol abuse, senility or mental and nervous disorders. The covered expenses which are allowed with convalescent care include the facility's semi-private rate charge and most of the services and supplies provided by the facility. Physicians' charges are charges for special or private duty nursing are excluded.
3. ***Home Health Care***-Benefits may be provided as set forth in the Schedule of Benefits.
4. ***Hospice Care***-Benefits may be provided as set forth in the Schedule of Benefits.
5. ***Miscellaneous***-Benefits are not provided for routine medical examinations, immunizations, routine dental, vision and hearing expenses unless covered as set forth in the Schedule of Benefits.

## What Special Benefits Are Provided? (continued)

6. **Organ Transplants**-Pancreatic transplants without simultaneous kidney transplants are not covered. Transplants of cornea, kidney and skin are treated as any other illness, but donor charges are not covered. Special rules apply to other transplants such as heart, kidney/pancreas, lung, heart/lung, liver, allogenic and autologous bone marrow, and peripheral stem cell. Special rules include, but are not limited to, the following:
- Donor charges are not covered, but up to \$20,000.00 may be paid to acquire a heart, liver, lung or bone marrow.
  - Certain organ transplant procedures may not be covered under this plan. See Schedule of Benefits.
  - The covered services or supplies must be medically necessary and furnished in Designated Transplant Facilities, as determined by the Plan Supervisor.
  - A second opinion may be required.
  - You must be covered under the Plan for at least six months, preexisting provisions notwithstanding. Transplant procedures must be specifically pre-approved by the Plan Supervisor as meeting all requirements before such procedures are performed.

Whenever a covered organ transplant is contemplated, the prospective recipient must contact the Plan Supervisor's Transplant Coordinator, at 1 (800) 849-2941, prior to the scheduling of the transplant evaluation in order for such procedure to be covered. The Plan Supervisor will furnish the prospective transplant recipient or such recipient's physician with the names of Designated Transplant Facilities approved by the Plan Supervisor.

If you have questions about your Organ Transplant Benefit, review your Plan Document or consult your Plan Supervisor.

### **WHAT ABOUT PREEXISTING CONDITIONS?**

Full coverage may not be available to you or your dependents because of a preexisting condition. Please note the preexisting condition rules in the Schedule of Benefits. If you or a dependent has a preexisting condition, benefits may be reduced or denied during the early months of coverage (Post-Coverage Period) under the Plan due to medical care received in the months prior to your *Enrollment Date* (Pre-Coverage Period).

These preexisting limitations do not apply if you were covered on the Plan's Effective Date. However, the Plan will not pay more for your preexisting condition than you would have received under your previous plan. Pregnancy and/or conception are not treated as a preexisting condition. In addition, genetic testing without a diagnosis is also not deemed to be preexisting.

The Plan does not intend to give immediate benefits for preexisting conditions to newly Covered Persons nor to increase benefits for preexisting conditions to previously Covered Persons.

## Credit for Periods of Previous Coverage

Upon receipt of a valid Certificate of Creditable Coverage, this Plan will give credit for previous coverage, towards satisfaction of the preexisting condition provision of this Plan, provided such coverage is from a creditable plan as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and provided there has not been a *Significant Break in such Coverage* of sixty-three (63) consecutive days or more. Significant breaks in coverage for an individual Alternative Method benefit category that occur during the most recent three-hundred sixty five (365) cumulative days of creditable coverage, or in the case of a *Late Enrollee*, five-hundred forty six (546) cumulative days of creditable coverage, will not be considered for the Alternative Method benefit categories shown in the Schedule of Benefits. Waiting periods and affiliation periods for HMO coverage are not considered breaks in coverage. Days in a waiting period are not creditable coverage.

This Plan may modify its initial determination if it later determines that a Covered Person does not have the creditable coverage that was claimed. In this circumstance, this Plan will notify you of its reconsideration.

Upon request, this Plan will assist you in obtaining a Certificate of Creditable Coverage from any prior plan or issuer for you or any of your covered dependents. If a Certificate of Creditable Coverage cannot be obtained, this Plan will take into account all information that it obtains or that is presented on your behalf or on behalf of your covered dependents to make a determination.

This Plan will automatically issue a Certificate of Creditable Coverage when you or any covered dependent ceases to be a Covered Person or when you or any covered dependent becomes covered under COBRA; and when COBRA coverage expires. In addition, this Plan will issue a Certificate of Creditable Coverage upon request from you before losing coverage or anytime within twenty-four (24) months after the date of loss of coverage.

## Alternative Method of Crediting Previous Coverage

This Plan has elected to use the Alternative Method (specific benefits are considered) to determine the amount of Creditable Coverage for the benefit categories shown in the Schedule of Benefits. This means that creditable coverage will be counted within a benefit category only if some level of benefit is provided within that benefit category. For example, prior dental care coverage would count as creditable coverage only with respect to new dental care coverage. Dental care coverage will not count a creditable coverage with respect to medical coverage or any other non-dental health care coverage.

## How Does This Plan Coordinate With Other Plans?

Your Plan intends that no more than a certain percentage of your expenses are to be covered by this Plan and similar plans. This certain percentage is set forth in the Schedule of Benefits as the Coordination of Benefits (COB) Percent. Similar plans are group plans and plans which operate like group plans. Also, the method of determining secondary/primary for dependent children is set forth in the Schedule of Benefits. In coordinate with other plans, the one which pays first is usually the one which covers the claimant as the Participant (and not the dependent). The one which is secondary is the one which covers the claimant as the dependent (and not the Participant). This Plan will always be secondary to non-COBRA coverage. This Plan is also secondary to any plan or coverage provided to any person due to such person's residency or citizenship status with a foreign country or other foreign governmental entity.

## Medicare

Your plan generally will be primary and Medicare secondary when you are covered as an active-worker participant (and not as a retiree or permanently disabled participant). When you are an active-worker participant and your covered spouse has a Medicare card, your plan will be primary to such Medicare. Special rules involve active-worker participants who have a Medicare care and are in small plans (employers with fewer than 100 employees). Additionally, special rules apply to participants with end stage renal disease. Call the Plan Supervisor for details.

## Extension of Coverage Provisions

Your coverage ceases when you fail to meet the actively-at-work requirement but are still an Employee unless either one of the following two conditions are met:

1. *Automatic Extension*-If you are totally disabled, your coverage will be automatically extended for the disability extension period as set forth in the Schedule of Benefits.
2. *Discretionary Extension*-The Employer may extend your coverage for a period not to exceed the maximum leave of absence or as a discretionary leave of absence, such as for layoffs as set forth in the Schedule of Benefits. Such leave must be evidenced by a written intention such as an Employer board resolution, a letter signed by an Employer's officer or a similar document.

The above-cited extensions also include your covered dependents, if any. These coverage extensions are terminated if for any reason your employment is terminated or the Plan is terminated. See COBRA rights.

## May You Convert Your Coverage?

At the end of your full Continuation of Coverage Period (e.g., three (3) years or eighteen (18) months), conversion to an individual policy of medical coverage *may* be allowed if so indicated in the Schedule of Benefits and is offered to all Plan participants. This conversion policy will have more restrictive provisions and will have less favorable benefits than your group Plan. If the Plan does offer Conversion, contact your Plan coordinator for details.

## **What Are Your Rights Of Continuation?**

See Appendix 1-COBRA.

## **What Rules Does The Plan Follow In Claims Processing?**

See Appendix 2-Claims Procedures.

## **What Medical Privacy Rules Does The Plan Follow?**

See Appendix 3-Medical Privacy Procedures.

# COBRA APPENDIX

## INITIAL COBRA NOTICE

### *COBRA Coverage-Summary of Rights and Obligations Regarding Continuation of Coverage under the Medical and/or Dental Plan*

Both you (the employee) and your spouse should read this summary carefully and keep it with your records.

Federal law requires most employers sponsoring a group health plan to offer employees and their families the opportunity to elect a temporary extension of health coverage (called “continuation coverage” or “COBRA coverage”) in certain instances where coverage under the group health plan would otherwise end. The employer’s group health plan will be referred to in this Notice as “Plan.” You do not have to show that you are insurable to elect continuation coverage.

This notice is intended only to summarize your rights and obligations under the law. The Plan offers no greater COBRA right than what the COBRA laws require and this Notice should be construed accordingly. The COBRA laws are not always clear on some points and are interpreted by Federal agencies and the courts. Since Congress often changes the laws, this summary is subject to change without notice as interpretations or changes of law occur.

### Qualifying Events

**Covered Employee:** If you are a covered employee, you have the right to elect continuation coverage if you lose coverage under the Plan due to either of the following Qualifying Events:

1. Termination (for reasons other than gross misconduct) of your employment; or
2. Reduction in the number of hours worked.  
(The maximum continuation period for the above is 18 months.)

**Covered Spouse of Covered Employee:** If you are a covered spouse of an employee covered under the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan due to any of the following Qualifying Events:

1. The termination (except for gross misconduct) or a reduction in hours of your covered spouse’s employment;  
(The maximum continuation period for Event 1 is 18 months.)
2. The death of your covered spouse; or
3. Divorce or legal separation from your covered spouse.  
(The maximum continuation period for Events 2 and 3 is 36 months.)

## Qualifying Events (continued)

**Covered Dependent Child of Covered Employee:** If you are a covered dependent child of an employee covered under the Plan, you have the right to elect continuation coverage if your coverage is lost due to any of the following Qualifying Events:

1. The termination of covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment with the Employer;  
(The maximum continuation period for Event 1 is 18 months.)
2. The death of your covered parent/employee;
3. Divorce or legal separation of your covered parent; or
4. You cease to be a "dependent child" under the Plan.  
(The maximum continuation period for Events 2, 3 and 4 is 36 months.)

Similar rights may apply to certain retirees, spouses and dependent children if your employer commences bankruptcy proceedings and these individuals lose coverage.

## Notices and Elections

Under the COBRA laws, it is the responsibility of the employee or family member to notify the Plan Administrator in writing in the event of a divorce, legal separation or a child losing dependent status. The necessary legal documentation supporting any of these changes must accompany the written notice. You (the employee) or a family member must give this written notice no later than sixty (60) days from the date of the event. If you or a family member fail to notify the Plan Administrator in writing during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. If your marital status changes or you or your spouse's address changes, you must immediately notify the Plan Administrator in writing. Further, if you or a family member fails to notify the Plan Administrator, and contrary to Plan terms, any claims are paid for expenses incurred, then you and your family members will be required to reimburse the Plan for any claims paid.

If the Plan Administrator is properly notified of a divorce, legal separation, or a child losing dependent status that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect COBRA continuation coverage. If an employee drops his or her spouse from coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the spouse lost coverage earlier. If the employee or any qualified beneficiary notifies the administrator in writing within sixty (60) days of the divorce or legal separation, and can establish that the coverage was dropped earlier in anticipation of divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation. In the event that a divorce decree is later determined to be invalid and COBRA continuation coverage is terminated due to lack of a qualifying event, the former spouse will be responsible for reimbursing the Plan for all claims that were paid during the interim.

## Notices and Elections (continued)

You (the employee) and/or your family members will also be notified automatically upon the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct); reduction in covered employee's work hours; or death of the employee.

The covered employee and/or each covered family member has individual rights under COBRA during the sixty (60) day election period. Each Qualified Beneficiary must elect continuation coverage in writing within sixty (60) days from the later of the benefit termination date or the date the notice is provided by the Plan Administrator. An employee, spouse or a third party may elect COBRA continuation for all qualified beneficiaries. An employee, spouse or a third party may not reject COBRA coverage on behalf of other qualified beneficiaries, except minor children. Elections are allowed to be changed only during the initial sixty (60) day election period. If you or your family members do not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. If a Qualified Beneficiary waives continuation coverage and later revokes the waiver in writing within the sixty (60) day election period, the COBRA effective date is the day the waiver is revoked rather than the day following the Qualifying Event. There will be a loss of coverage during the time coverage was waived. Your election is considered to be made on the day it is sent to the Plan Supervisor or Plan Administrator.

## Type of Coverage; Premium Payments

If COBRA coverage is elected, the employer must provide the same type of coverage provided under the Plan to similarly situated employees or family members. If coverage for similarly situated employees or family members is modified, COBRA coverage will be modified in the same way.

You must pay the entire premium for your COBRA coverage. The rates include a two percent (2%) administrative fee that is added on to the premium amount. These rates are subject to change on the anniversary date of each Plan Year.

Initial payment of premiums for COBRA coverage must be postmarked on or before the forty-fifth (45<sup>th</sup>) day after electing COBRA coverage. Your initial payment must be at least enough to pay premiums due for all prior months of continuation coverage, not excluding the month in which you are making the initial payment. If the full initial premium is not paid within the forty-five (45)-day period, coverage for the affected Qualified Beneficiary(ies) remains canceled and no coverage continuation will be provided.

After the initial premium, your premium must be postmarked within thirty (30) days of the due date. Although premium coupons will be mailed to you, even if you do not receive the coupons it is your responsibility to remit payment within the time period. Premium payments must be made by check or money order. Premium billing notices will not be sent and your only receipt will be your canceled check or money order copy. Your premium payment is considered to be made on the date it is sent.

## **Extension of 18 Month Maximum**

A second Qualifying Event (same as others listed above in addition to Medicare Entitlement) which occurs during the initial eighteen (18) month or twenty-nine (29) month continuation period, may extend the COBRA continuation period to up to thirty-six (36) months from the date of the initial Qualifying Event for Qualified Beneficiaries. This second Qualifying Event occurrence would not apply to the covered employee. In no event will continuation coverage last beyond thirty-six (36) months from the date of the event that originally made a Qualifying Beneficiary eligible to elect coverage.

The COBRA Qualified Beneficiary is responsible for notifying the Plan Administrator in writing if a second qualifying event occurs during the initial eighteen (18) or twenty-nine (29) month continuation period. The Plan Administrator must receive this written notification within sixty (60) days of the second qualifying event and before the end of the initial eighteen (18) or twenty-nine (29) month continuation period or extended coverage will not be available. If you or a family member fail to notify the Plan Administrator in writing during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage.

## **Disability Extension**

If a COBRA Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of the benefit termination or during the first sixty (60) days of COBRA continuation coverage, the initial eighteen (18) month continuation period may be extended to a maximum of twenty-nine (29) months. The Qualified Beneficiary must provide the Plan Administrator notice of the disability determination within sixty (60) days of the date of the determination, regardless of the timeframe in which the determination is received; (Example: A child who is deemed disabled during the active employment of the parent receives a determination of disability. This notice would have to be submitted within sixty (60) days of the date of the determination letter, even though he/she is covered under the plan as a dependent and the covered parent is still employed). The Plan Administrator must receive this written notice of the disability determination within (60) days of the date of the determination and before the eighteen (18) month continuation period expires. The additional eleven (11) month extension period is available to each family member of the disabled Qualified Beneficiary, provided the family member is also a COBRA Qualified Beneficiary. If a newborn or adopted child is disabled and added to the COBRA continuation coverage of the Primary Qualified beneficiary, the sixty (60) day requirement for disability determination will be measured from the date of birth or placement for adoption. If Medicare entitlement occurs during the eleven (11) month extension period, the COBRA Qualified Beneficiary must notify the Plan Administrator.

If the Disabled COBRA Participant's condition improves and a final determination is made by the Social Security Administration that the affected Participant is no longer disabled and no longer entitled to Disability Benefits, the Plan Administrator must be notified in writing within thirty (30) days from the final determination date by the affected individual. During the eleven (11) month extension period, COBRA continuation coverage for each Qualified Beneficiary will be determined as of the first of the month that began more than thirty (30) days after such final determination.

## **Newborn Children of, or Children Placed for Adoption with, the Primary Qualified Beneficiary and Other Newly Acquired Dependents**

A child born to or placed for adoption with the covered Primary Qualified Beneficiary (former employee) during the period of continuation coverage, the child is considered a Qualified Beneficiary. The Primary Qualified Beneficiary (former employee) or a family member also covered under COBRA continuation coverage must notify the Plan Administrator in writing within thirty (30) days of the birth, adoption or placement to enroll the child in COBRA. The necessary legal documentation supporting the birth, adoption or placement must accompany the written notice.

Other newly acquired dependents may be enrolled in COBRA if written notification is received within thirty days of the acquisition date from the Qualified Beneficiary. These dependents will only be allowed to have continuation coverage as long as the Qualified Beneficiary is covered under COBRA. In no instance will coverage be extended past the last day in which the Qualified Beneficiary is covered under COBRA.

## **Termination of Cobra Continuation Coverage**

There are specific events under the COBRA laws which will result in the termination of the COBRA continuation coverage prior to the end of the maximum continuation period:

- The employer no longer provides health care coverage to any of its employees;
- The premium for the continuation coverage is not paid on time;
- The COBRA Qualified Beneficiary becomes covered under another group health plan after election of COBRA (whether as an employee or otherwise) unless the plan contains any exclusions or limitations with respect to any preexisting condition the Qualified Beneficiary or covered dependents may have;
- Becoming entitled to Medicare after the election of COBRA;
- The COBRA Qualified Beneficiary's coverage has been extended to twenty-nine (29) months due to his or her disability and a final determination has been made that the Qualified Beneficiary is no longer disabled. In this case the affected individual must notify the Plan Administrator within thirty (30) days of such determination; or
- Occurrence of any event (e.g. submission of fraudulent claims) that permits termination of coverage for cause with respect to covered employees or their spouses for a reason other than the COBRA coverage requirements under Federal Law.

## **Administrative Clarifications**

The **Plan Administrator** is your previous employer with whom you have COBRA Continuation Coverage.

The **Plan Supervisor** is \_\_\_\_\_.

# **Appendices to a Health Care Plan Summary Plan Description (SPD)**

## **In Three Parts**

- 1. Cobra Notice**
- 2. Claims Procedures**
- 3. Medical Privacy Procedures**

**These Appendices are attached to and made part  
of the following Health Care Plan**

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**Date of Appendices** \_\_\_\_\_

# COBRA NOTICE

## Introduction

Federal law requires most employers sponsoring a group health plan to offer employees and their families the opportunity to elect a temporary extension of health coverage (called *continuation coverage* or *COBRA coverage*) in certain instances where coverage under the group health plan would otherwise end. The employer's group health plan will be referred to in this Notice as "Plan." You do not have to show that you are insurable to elect continuation coverage. Both you and your spouse should read this summary carefully and keep it with your records.

This notice is intended only to summarize your rights and obligations under the law. The Plan offers no greater COBRA right than what COBRA laws require and this Notice should be construed accordingly. The COBRA laws are not always clear on some points and are interpreted by Federal agencies and the courts. Since Congress often changes the laws, this summary is subject to change without notice as interpretations or changes of law occur.

## Qualifying Events

**Covered Employee:** If you are a covered employee, you have the right to elect continuation coverage if you lose coverage under the Plan due to either of the following Qualifying Events:

1. Termination (for reasons other than gross misconduct) of your employment
2. Reduction in the number of hours worked.  
(The maximum continuation period for the above is 18 months.)

**Covered Spouse of Covered Employee:** If you are a covered spouse of an employee covered under the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan due to any of the following Qualifying Events:

1. The termination (except for gross misconduct) or a reduction in hours of your covered spouse's employment.  
(The maximum continuation period for Event 1 is 18 months.)
2. The death of your covered spouse
3. Divorce or legal separation from your covered spouse.  
(The maximum continuation period for Events 2 and 3 is 36 months.)

## Qualifying Events (continued)

**Covered Dependent Child of Covered Employee:** If you are a covered dependent child of an employee covered under the Plan, you have the right to elect continuation coverage if your coverage is lost due to any of the following Qualifying Events:

1. The termination of covered parent's employment (for reasons other than gross misconduct) or reduction in the covered parent's hours of employment with the Employer  
(The maximum continuation period for Event 1 is 18 months.)
2. The death of your covered parent/employee
3. Divorce or legal separation of your covered parent
4. You cease to be a *dependent child* under the Plan.  
(The maximum continuation period for Events 2, 3 and 4 is 36 months.)

Similar rights may apply to certain retirees, spouses and dependent children if your employer commences bankruptcy proceedings and these individuals lose coverage.

## Notices and Elections

Under the COBRA laws, it is the responsibility of the employee or family member to notify the Plan Administrator in writing in the event of a divorce, legal separation or a child losing dependent status. The necessary legal documentation supporting any of these changes must accompany the written notice. You (the employee) or a family member must give this written notice no later than sixty (60) days from the date of the event. If you or a family member fail to notify the Plan Administrator in writing during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. If your marital status changes or you or your spouse's address changes, you must immediately notify the Plan Administrator in writing. Further, if you or a family member fails to notify the Plan Administrator, and contrary to Plan terms, any claims are paid for expenses incurred, then you and your family members will be required to reimburse the Plan for any claims paid.

If the Plan Administrator is properly notified of a divorce, legal separation, or a child losing dependent status that has caused a loss of coverage, the Plan Administrator will notify the affected family member of the right to elect COBRA continuation coverage. If an employee drops his or her spouse from coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the spouse lost coverage earlier. If the employee or any qualified beneficiary notifies the administrator in writing within sixty (60) days of the divorce or legal separation, and can establish that the coverage was dropped earlier in anticipation of divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation. In the event that a divorce decree is later determined to be invalid and COBRA continuation coverage is terminated due to lack of a qualifying event, the former spouse will be responsible for reimbursing the Plan for all claims that were paid during the interim.

## Notices and Elections (continued)

You (the employee) and/or your family members will also be notified automatically upon the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct); reduction in covered employee's work hours; or death of the employee.

The covered employee and/or each covered family member has individual rights under COBRA during the sixty (60) day election period. Each Qualified Beneficiary must elect continuation coverage in writing within sixty (60) days from the later of the benefit termination date or the date the notice is provided by the Plan Administrator. An employee, spouse or a third party may elect COBRA continuation for all qualified beneficiaries. An employee, spouse or a third party may not reject COBRA coverage on behalf of other qualified beneficiaries, except minor children. Elections are allowed to be changed only during the initial sixty (60) day election period. If you or your family members do not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. If a Qualified Beneficiary waives continuation coverage and later revokes the waiver in writing within the sixty (60) day election period, the COBRA effective date is the day the waiver is revoked rather than the day following the Qualifying Event. There will be a loss of coverage during the time coverage was waived. Your election is considered to be made on the day it is sent to the Plan Supervisor or Plan Administrator.

## Type of Coverage; Premium Payments

If COBRA coverage is elected, the employer must provide the same type of coverage provided under the Plan to similarly situated employees or family members. If coverage for similarly situated employees or family members is modified, COBRA coverage will be modified in the same way.

You must pay the entire premium for your COBRA coverage. The rates include a two percent (2%) administrative fee that is added on to the premium amount. These rates are subject to change on the anniversary date of each Plan Year.

Initial payment of premiums for COBRA coverage must be postmarked on or before the forty-fifth (45<sup>th</sup>) day after electing COBRA coverage. Your initial payment must be at least enough to pay premiums due for all prior months of continuation coverage, not excluding the month in which you are making the initial payment. If the full initial premium is not paid within the forty-five (45)-day period, coverage for the affected Qualified Beneficiary(ies) remains canceled and no coverage continuation will be provided.

After the initial premium, your premium must be postmarked within thirty (30) days of the due date. Although premium coupons will be mailed to you, even if you do not receive the coupons it is your responsibility to remit payment within the time period. Premium payments must be made by check or money order. Premium billing notices will not be sent and your only receipt will be your cancelled check or money order copy. Your premium payment is considered to be made on the date it is sent.

## **Extension of 18 Month Maximum**

A second Qualifying Event (same as others listed above in addition to Medicare Entitlement) which occurs during the initial eighteen (18) month or twenty-nine (29) month continuation period, may extend the COBRA continuation period to up to thirty-six (36) months from the date of the initial Qualifying Event for Qualified Beneficiaries. This second Qualifying Event occurrence would not apply to the covered employee. In no event will continuation coverage last beyond thirty-six (36) months from the date of the event that originally made a Qualifying Beneficiary eligible to elect coverage.

The COBRA Qualified Beneficiary is responsible for notifying the Plan Administrator in writing if a second qualifying event occurs during the initial eighteen (18) or twenty-nine (29) month continuation period. The Plan Administrator must receive this written notification within sixty (60) days of the second qualifying event and before the end of the initial eighteen (18) or twenty-nine (29) month continuation period or extended coverage will not be available. If you or a family member fail to notify the Plan Administrator in writing during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage.

## **Disability Extension**

If a COBRA Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of the benefit termination or during the first sixty (60) days of COBRA continuation coverage, the initial eighteen (18) month continuation period may be extended to a maximum of twenty-nine (29) months. The Qualified Beneficiary must provide the Plan Administrator notice of the disability determination within sixty (60) days of the date of the determination, regardless of the timeframe in which the determination is received; (Example: A child who is deemed disabled during the active employment of the parent receives a determination of disability. This notice would have to be submitted within sixty (60) days of the date of the determination letter, even though he/she is covered under the plan as a dependent and the covered parent is still employed). The Plan Administrator must receive this written notice of the disability determination within (60) days of the date of the determination and before the eighteen (18) month continuation period expires. The additional eleven (11) month extension period is available to each family member of the disabled Qualified Beneficiary, provided the family member is also a COBRA Qualified Beneficiary. If a newborn or adopted child is disabled and added to the COBRA continuation coverage of the Primary Qualified beneficiary, the sixty (60) day requirement of disability determination will be measured from the date of birth or placement for adoption. If Medicare entitlement occurs during the eleven (11) month extension period, the COBRA Qualified Beneficiary must notify the Plan Administrator.

If the Disabled COBRA Participant's condition improves and a final determination is made by the Social Security Administration that the affected Participant is no longer disabled and no longer entitled to Disability Benefits, the Plan Administrator must be notified in writing within thirty (30) days from the final determination date by the affected individual. During the eleven (11) month extension period, COBRA continuation coverage for each Qualified Beneficiary will be determined as of the first of the month that began more than thirty (30) days after such final determination.

## **Newborn Children of, or Children Placed for Adoption With, the Primary Qualified Beneficiary and Other Newly Acquired Dependents**

A child born to or placed for adoption with the covered Primary Qualified Beneficiary (former employee) during the period of continuation coverage, the child is considered a Qualified Beneficiary. The Primary Qualified Beneficiary (former employee) of a family member also covered under COBRA continuation coverage must notify the Plan Administrator in writing within thirty (30) days of the birth, adoption or placement to enroll the child in COBRA. The necessary legal documentation supporting the birth, adoption or placement must accompany the written notice.

Other newly acquired dependents may be enrolled in COBRA if written notification is received within thirty days of the acquisition date from the Qualified Beneficiary. These dependents will only be allowed to have continuation coverage as long as the Qualified Beneficiary is covered under COBRA. In no instance will coverage be extended past the last day in which the Qualified Beneficiary is covered under COBRA.

## **Termination of Cobra Continuation Coverage**

There are specific events under the COBRA laws which will result in the termination of the COBRA continuation coverage prior to the end of the maximum continuation period:

- The employer no longer provides health care coverage to any of its employees;
- The premium for the continuation coverage is not paid on time;
- The COBRA Qualified Beneficiary becomes covered under another group health plan after election of COBRA (whether as an employee of otherwise) unless the plan contains any exclusions or limitations with respect to any preexisting condition the Qualified Beneficiary or covered dependents may have;
- Becoming entitled to Medicare after the election of COBRA;
- The COBRA Qualified Beneficiary's coverage has been extended to twenty-nine (29) months due to his or her disability and a final determination has been made that the Qualified Beneficiary is no longer disabled. In this case the affected individual must notify the Plan Administrator within thirty (30) days of such determination; or
- Occurrence of any event (e.g. submission of fraudulent claims) that permits termination of coverage for cause with respect to covered employees or their spouses for a reason other than the COBRA coverage requirements under Federal Law.

# CLAIMS PROCEDURES

## Claims Review Procedures

Claims for benefits will be reviewed by the Plan in accordance with the following procedures. The Plan's claims review procedures vary depending on the type of claim filed. Your claims may be any one of the following 3 types of claims:

- Pre-Service Claim- A Pre-Service Claim is a claim for medical care under the Plan for which prior approval for the care, in whole or part, is a condition to receiving the medical care.
- Concurrent Care Claim-a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments (e.g. chemotherapy treatments).
- Post-Service Claim-a claim for medical care for which the medical care has already been received by the claimant.

In addition, a Pre-Service or Concurrent Care Claim may involve *Urgent Care*. A Pre-Service or Concurrent Care Claim involving Urgent Care is one in which the application of the time period for making a determination of a Pre-Service or Concurrent Care Claim will seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition) or will subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

In each situation below where we reference *you* we also mean a third party representative who has been authorized to file claims on your behalf in accordance with the Plan Administrator's policies and procedures for third party authorization. In the case of an Urgent Care Claim, the health care professional with knowledge of the claimant's condition will always be considered an authorized representative.

## **Pre-Service Claim**

If you file a Pre-Service Claim, you will be notified of the benefit determination (whether adverse or not) within a reasonable period of time but not later than 15 days after the Plan Supervisor's receipt of the claim. This period may be extended one time for up to 15 days for reasons beyond the control of the Plan Supervisor if you are notified, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If an extension is necessary due your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be given at least 45 days from receipt of the notice to provide the specified information. The Plan Supervisor's time period for making a determination will be suspended until you provide the information or the end of the 45-day period, whichever occurs first.

If you file a Pre-Service Claim that is also an Urgent Care Claim, you will be notified of the Plan Supervisor's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after the Plan Supervisor receives your claim. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, you will be notified as soon as possible, but not later than 24 hours after receipt of the Plan Supervisor's receipt of your Urgent Care Claim, of the specific information necessary to complete your Urgent Care Claim. You must provide the information within a reasonable time but no later than 48 hours after notice of the need for information. You will be notified of the Plan Supervisor's benefit determination as soon as possible but no later than 48 hours after the earlier of (i) the receipt of the requested information, or (ii) the end of the period 48 hour period, whichever occurs first.

## **Concurrent Care Claim**

If an ongoing course of treatment has been approved under the terms of the Plan, any reduction or termination of your ongoing course of treatment (other than by Plan amendment or Plan termination) you will be notified of any determination to reduce or stop the ongoing course of treatment within a reasonable amount of time prior to the reduction or termination to allow you to appeal and obtain a determination prior to the effective date of the reduction or termination of your ongoing course of treatment.

If you request to extend an ongoing course of treatment beyond the scheduled end of the ongoing treatments and your request involves an Urgent Care Claim, you will be notified of the benefit determination, whether adverse or not, within 24 hours after receipt of your claim by the Plan Supervisor, provided that your claim is made to the Plan at least 24 hours prior to the expiration of the ongoing course of treatment. Otherwise, the Plan Supervisor will treat the claim in the same manner as any other claim involving Urgent Care.

## **Post-Service Claim**

If you file a Post-Service Claim that is denied in whole or part, you will be notified within a reasonable period of time but not later than 30 days after the Plan Supervisor's receipt of your claim. This period may be extended up to 15 days if an extension is necessary due to matters beyond the control of the Plan Supervisor and you are notified, prior to the end of the initial 30

day period, of the circumstances requiring the extension of time and the date by which a decision will be rendered. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information that is missing, and you will be provided at least 45 days from receipt of the notice to provide the specified information. The Plan Supervisor's time period for making a determination will be suspended until you provide the information or the end of the 45-day period, whichever occurs first.

The period of time within which a benefit determination is required to be made will begin at the time your claim is filed with the Plan Supervisor. A claim is filed with the Plan Supervisor as set forth in the Schedule of Benefits.

## **Notice of Benefit Determination**

If your claim is denied in whole or in part (or for Pre-Service Claims or claims involving Urgent Care, if your claim is approved or denied), the Plan Supervisor will provide you with a written or electronic notification (when permitted by applicable rules and regulations) setting forth the following information:

1. The specific reason or reasons for the denial
2. The specific provisions of the Plan on which the denial is based
3. A description of any additional material or information necessary for you to perfect your claim, together with an explanation as to why such material or information is necessary
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
7. If the claim was an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If your Urgent Care Claim was denied in whole or part, the notice may be provided to you orally; however, a written or electronic notification will be provided to you not later than 3 days after the oral notification.

## Appealing a Denied Claim

If your claim for benefits other than a Concurrent Care Claim has been denied in whole or in part by the Plan Supervisor, you may request a review of the denial by the Plan Administrator by filing a written (or oral if the claim involves an Urgent Care Claim) appeal to the Plan Administrator within 180 days of the Plan Supervisor's denial. The appeal must be filed in accordance with the instructions in the Plan Supervisor's denial letter. In addition, the Plan Supervisor's denial letter will notify you of the time period in which you must file an appeal of a reduction or termination of a Concurrent Care Claim. As part of the appeal process, the Plan Administrator will:

1. Provide you the opportunity to submit written comments, documents, records, and other information relating to your claim for benefits
2. Provide that you will be furnished, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits
3. Provide for a review that takes into account all comments, documents, records and other information submitted by you relating to your claim, without regard to whether such information was submitted or considered in the initial benefit determination
4. Provide for a review that does not afford deference to the initial denial by the Plan Supervisor
5. Provide that, in deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional may not be 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
6. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with denial of your claim, without regard to whether the advice was relied upon in making the benefit determination
7. Provide, in the case of an Urgent Care Claim, for an expedited review process pursuant to which (i) a request for an expedited appeal of denial may be submitted orally or in writing by you and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious methods.

The period of time within which a benefit determination of an appealed claim is required to be made varies by the type of claim. Notwithstanding the type of claim, the time period for making a determination will begin at the time an appeal is filed with the Plan Administrator in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

## **Pre-Service/Concurrent Care Claim**

In the case of a Pre-Service Claim or Concurrent Care Claim, the Plan Administrator will notify you of the Plan's benefit determination of an appealed claim not later than 30 days after receipt by the Plan Administrator of your request for review.

## **Urgent Care Claim**

In the case of an appeal of a denied Pre-Service Claim or Concurrent Care Claim that is an Urgent Care Claim, the Plan Administrator will notify you of the Plan's benefit determination not later than 72 hours after receipt by the Plan Supervisor of your request for review.

## **Post Service Claim**

The Plan Administrator will notify you of the Plan's benefit determination on review within a reasonable period time, but not later than 60 days after receipt by the Plan Administrator of your request for review of an adverse benefit determination.

## **Notice of Adverse Benefit Determination Upon Review**

If your claim is denied on review, the Plan Administrator will provide you with a written or electronic notification setting forth the following information:

1. The specific reason or reasons for the denial
2. The specific provisions of the Plan on which the denial is based
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim
4. A statement describing the Plan's voluntary appeal process, if any
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to you upon request
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request
7. A statement indicating that you may have the right to bring a civil suit in federal court in accordance with ERISA Section 502(a).

## Miscellaneous Information

### Two Levels of Appeals

The Plan Administrator may, in its sole discretion, require two levels of mandatory appeals following an initial denial by the Plan Supervisor of any claim other than an Urgent Care Claim. If so, you will be notified of the procedures for filing each level of appeal. Each level of appeal is subject to the same rules and regulations described above under *Appeals of a Denied Claim* except that you will not have 180 days in which to file your second level of appeal. You will be notified the time frame for filing a second appeal. In addition, the time period during which a determination must be made for one appeal will be split evenly for each level of appeal. Each level of appeal will be conducted by an appropriate named fiduciary identified in the denial letter who was not involved in the previous determination nor was a subordinate of someone who was.

### Legal Action

Any legal action following a final determination from the Plan Administrator must be commenced within the time frames set forth in the Schedule of Benefits or you will lose the right to take legal action. You may only take legal action after you have exhausted the Plan's claims review procedures described above.

### Disability Determination

If the Plan offers an extension for participants on the basis of disability (as set forth in the Schedule of Benefits) and the Plan Administrator is ultimately responsible for making the determination as to whether a participant is indeed disabled, same rules that apply to Post-Service Claims apply to claims for disability with the following exceptions:

- The Plan Supervisor will notify you of an adverse benefit determination within 45 days of receipt of the claim. The Plan Supervisor may take two extensions of 30 days each if for reasons beyond the control of the Plan Supervisor.
- The Plan Administrator will notify you of an adverse benefit determination within 45 days of the date the Plan Supervisor received the appeal. The Plan Administrator may take a 45-day extension if for reasons beyond the control of the Plan Administrator.

# MEDICAL PRIVACY PROCEDURES

## Introduction

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.**

If you have any questions about this notice, please contact your Plan Coordinator.

During the course of providing you with health coverage, the Plan will have access to information about you that is deemed to be *Protected Health Information*, or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The procedures outlined in this section have been added to the Plan to ensure that your PHI is treated with the level of protection required by HIPAA. This notice describes the medical information practices of your group health plan (the “Plan”) and that of any third party that assists in the administration of Plan claims.

## Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- make sure that medical information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Your PHI will be disclosed to certain employees of Employer. These individuals may only use your PHI for Plan administration functions including those described below, provided they do not violate the provisions set forth herein. Any employee of Employer who violates the rules for handling PHI established herein will be subject to adverse disciplinary action.

By adoption of this SPD, the Employer has certified that it will comply with the privacy procedures set forth herein. Employer may not use or disclose your PHI other than as provided herein or as required by law. Any agents or subcontractors who are provided your PHI must agree to be bound by the restrictions and conditions concerning your PHI found herein. Your PHI may not be used by Employer for any employment-related actions or decisions or in connection with any other benefit or employee benefit plan of Employer. Employer must report to the Plan any uses or disclosures of your PHI of which the Employer becomes aware that are inconsistent with the provisions set forth herein.

## **How We May Use and Disclose Medical Information about You**

The following categories describe different ways that we use and disclose medical information for purposes of health plan administration. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use medical information about you to facilitate medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

**For Payment.** We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations.** We may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with: conducting quality assessment and improvement activities; underwriting and soliciting bids from potential carriers, premium rating and setting employee contributions, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

## Special Situations

**Disclosure to Health Plan Sponsor.** Information may be disclosed to another health plan maintained by the Employer for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to the Employer's personnel solely for purposes of administering benefits under the Plan.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report child abuse or neglect
- To report reactions to medications or problems with products
- To notify a people of recalls of products they may be using
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for government to monitor the health care system, government programs, and compliance with civil rights laws.

## Special Situations (continued)

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official or in response to a court order, subpoena, warrant, summons or similar process:

- To identify or locate a suspect, fugitive, material witness, or missing person
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at the hospital
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

## Your Rights Regarding Medical Information about You

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to [the Plan Supervisor or Plan Administrator]. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. HIPAA provides several important exceptions to your right to access your PHI. For example, you will not be permitted to access psychotherapy notes or information compiled in anticipation of, or for use in, a civil, criminal or administrative action or proceeding. Employer will not allow you to access your PHI if these or any of the exceptions permitted under HIPAA apply. If you are denied access to medical information, you may request that the denial be reviewed.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to [insert appropriate contact]. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information which you would be permitted to inspect and copy
- Is accurate and complete.

Employer must act on your request for an amendment of your PHI no later than 60 days after receipt of your request. Employer may extend the time for making a decision for no more than 30 days, but it must provide you with a written explanation for the delay. If Employer denies your request, it must provide you a written explanation for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

**Right to an Accounting of Disclosures.** You have the right to request an *accounting of disclosures* (other than disclosures you authorized in writing) where such disclosure was made for any purpose other than treatment, payment, or health care operations.

## Your Rights Regarding Medical Information about You (continued)

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Supervisor. Your request must state a time period that may not be longer than six years and may not include dates before April 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Note that HIPAA provides several important exceptions to your right to an accounting of the disclosures of your PHI. For example, Employer does not have to account for disclosures of your PHI (i) to carry out treatment, payment or healthcare operations, (ii) to correctional institutions or law enforcement officials, or (iii) for national security or intelligence purposes. Employer will not include in your accounting any of the disclosures for which there is an exception under HIPAA. Employer must act on your request for an accounting of the disclosures of your PHI no later than 60 days after receipt of the request. Employer may extend the time for providing you an accounting by no more than 30 days, but it must provide you a written explanation for the delay. You may request one accounting in any 12-month period free of charge. Employer will impose a fee for each subsequent request within the 12-month period.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree to your request.*

To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. We will accommodate all requests we deem reasonable. Your request must specify how or where you wish to be contacted.

## **Your Rights Regarding Medical Information about You (continued)**

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Employer must make its internal practices, books and records related to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with these privacy protections.

When Employer no longer needs PHI disclosed to it by the Plan, for the purposes for which the PHI was disclosed, Employer must, if feasible, return or destroy the PHI that is no longer needed. If it is not feasible to return or destroy the PHI, Employer must limit further uses and disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

### **Changes to This Notice**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will contain on the first page, in the top right-hand corner, the effective date.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Plan Administrator. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

### **Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.