CITY OF

BURLINGTON

Your

Employee Benefit

Health Plan

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CITY OF BURLINGTON

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NOTE:
All words that are capitalized and in bold type are defined terms. Refer to Definition Section.

Establishment Of The Plan

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by City of Burlington (the "**EMPLOYER**" "**PLAN ADMINISTRATOR**" or the "**PLAN SPONSOR**") as of January 1, 2015, hereby sets forth the provisions of the City of Burlington Employee Group Health Care **PLAN** (the "**PLAN**").

- **Effective Date**

  The **PLAN** Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, January 1, 2015.

- **Adoption of the Plan Document**

  The **PLAN SPONSOR**, as the settlor of the **PLAN**, hereby adopts this Plan Document as the written description of the **PLAN**. [This Plan Document represents both the Plan Document and the Summary Plan Description. This **PLAN** Document amends and replaces any prior statement of the health care coverage contained in the **PLAN** or any predecessor to the **PLAN**.

IN WITNESS WHEREOF, the EMPLOYER has caused this Plan Document to be executed.

CITY OF BURLINGTON

By: Susan Leonard

Name: Susan Leonard

Title: Director of Human Resources

Date: 8/10/15

Introduction
And Purpose:
General Plan Information

- **Introduction and Purpose**

The **EMPLOYER** has established the **PLAN** for the benefit of eligible **EMPLOYEES**, in accordance with the terms and conditions described herein. **PLAN** benefits may be self-funded through a benefit fund or a trust established by the **PLAN SPONSOR** and self-funded with contributions from **PLAN COVERED PERSONS** and/or the **PLAN SPONSOR**, or may be funded solely from the general assets of the **PLAN SPONSOR**. **COVERED PERSONS** in the **PLAN** may be required to contribute toward their benefits.

The **PLAN SPONSOR**'s purpose in establishing the **PLAN** is to help offset, for eligible **EMPLOYEES**, the economic effects arising from a Non-occupational **INJURY** or **ILLNESS**. To accomplish this purpose, the **EMPLOYER** must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the **PLAN DOCUMENT**, to allow the **EMPLOYER** to allocate the resources available to help those individuals participating in the **PLAN** to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the **PLAN** that provide for the payment or reimbursement of all or a portion of certain expenses for hospital, medical, or dental benefits. The Plan Document is maintained by the **EMPLOYER** and may be inspected at any time during normal working hours by any **COVERED PERSONS**.

- **General Plan Information**

This **PLAN** has been established and operates under the guidelines of State of Vermont and Federal Laws. There is a requirement that certain disclosures must be made to **PLAN COVERED PERSONS**. The following pages provide this information.

1. NAME AND TYPE OF **PLAN**:

City of Burlington Employee Group Health Care **PLAN** to reimburse non-occupational **INJURY** and **ILLNESS** claims through contract administration by a **PLAN SUPERVISOR**.

2. Name and address of **EMPLOYER**:

City of Burlington
200 Church Street, Suite B
Burlington, VT 05401

3. NAME AND ADDRESS OF **PLAN ADMINISTRATOR** AND **PLAN SPONSOR**:

City of Burlington
200 Church Street, Suite B
Burlington, VT 05401
802-865-7150

4. INTERNAL REVENUE SERVICE **PLAN** IDENTIFICATION NUMBER AND TAX IDENTIFICATION NUMBER:

PLAN IDENTIFICATION NUMBER: **501**
TAX IDENTIFICATION NUMBER: 03-6000410

5. SOURCE OF FUNDING:

Self-Funded

6. APPLICABLE LAW:

   State of Vermont and Federal Laws

7. TYPE OF ADMINISTRATION:

   PLAN Administration by the **PLAN SUPERVISOR**.

8. THE NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF THE **PLAN SUPERVISOR**:

Mailing Address	Street Address
Group Insurance Service Center, Inc.	Group Insurance Service Center, Inc.
P.O. Box 9120	20 Winter Street
Marshfield, Massachusetts 02050	Pembroke, Massachusetts 02359

Telephone: (781) 829-8595

9. THE NAME OF THE PERSON OR PERSONS DESIGNATED AS AGENT FOR SERVICE OF LEGAL PROCESS AND ADDRESS AT WHICH PROCESS MAY BE SERVED ON SUCH PERSON:

   The **PLAN ADMINISTRATOR** noted in Item 3.

10. THE ELIGIBILITY REQUIREMENTS, TERMINATION PROVISIONS AND DESCRIPTION OF THE CIRCUMSTANCES WHICH MAY RESULT IN DISQUALIFICATION, INELIGIBILITY, DENIAL OR LOSS OF ANY **BENEFITS** ARE DESCRIBED IN THE SUMMARY PLAN DESCRIPTION.

11. SOURCE OF FINANCING OF THIS **PLAN** AND IDENTITY OF ANY ORGANIZATION THROUGH WHICH **BENEFITS** ARE PROVIDED:

    Contributions (which would be considered premiums) are made to this **PLAN** by the **EMPLOYER** and **EMPLOYEES**.

12. THE DATE OF THE **PLAN** YEAR:

    Each twelve (12) month period beginning on January 1st consists of an entire **PLAN** year for the purpose of accounting all reports to the U.S. Department of Labor and other regulatory bodies

13. **QMCSO** PROCEDURES:

    COVERED PERSONS and beneficiaries can obtain, without charge, a copy of the procedures governing qualified medical child support order (**QMCSO**) determinations by the **PLAN ADMINISTATOR.** To request a copy of the **QMCSO** procedures, contact the **PLAN ADMINISTRATOR** noted in Item 3.

14. LIST OF PROVIDERS:

    A list of providers is available online. Refer to the PPO section for the web address.

15. Information on specific topics can be found as follows:

Please review the document for other limitations and conditions on benefits provided under the **PLAN.**

- **Patient Protection and Affordable Care Act**

  This PLAN does not believe it is a "Grandfathered Health Plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). The **PLAN** will comply with the requirements under the Act in accordance with the Schedule outlined in the Act.

- **Legal Entity; Service of Process**

  The **PLAN** is a legal entity. Legal notice may be filed with, and legal process served upon, the **PLAN** Administrator.

- **Not a Contract**

  This Plan Document and any amendments constitute the terms and provisions of coverage under this **PLAN**. The Plan Document shall not be deemed to constitute a contract of any type between the **EMPLOYER** and any **COVERED PERSON** or to be consideration for, or an inducement or condition of, the employment of any **EMPLOYEE**. Nothing in this Plan Document shall be deemed to give any **EMPLOYEE** the right to be retained in the service of the **EMPLOYER** or to interfere with the right of the **EMPLOYER** to discharge any **EMPLOYEE** at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the **EMPLOYER** with the bargaining representatives of any **EMPLOYEE**s.

- **Mental Health Parity**

  Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this **PLAN** applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the **PLAN ADMINISTRATOR**.

- **Applicable Law**

  This is a self-funded benefit **PLAN**. The **PLAN** is funded with **EMPLOYEE** and/or **EMPLOYER** contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

- **Discretionary Authority**

  The **PLAN ADMINISTRATOR** shall have sole, full and final discretionary authority to interpret all **PLAN** provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the **PLAN** and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a **COVERED PERSONS**' rights; and to determine all questions of fact and law arising under the **PLAN**.

PLAN EFFECTIVE DATE: January 1, 2015

1. **EMPLOYER**: City of Burlington
2. ELIGIBILITY REQUIREMENTS:
   a. MINIMUM HOURS REQUIRED:
   REGULAR FULL-TIME: 20 hours per week
   b. **WAITING PERIOD**: None
   c. **EFFECTIVE DATE** OF COVERAGE: The first of the month or coincident with completion of the **WAITING PERIOD** providing forms are completed and filed as outlined in the Eligibility Section.
   d. REINSTATED: Same as new hire. Applicable large employers will allow an EMPLOYEE to be reinstated, not treated as a new hire, if they had a break in coverage of less than thirteen (13) weeks. If coverage lapses due to non-payment of contributions and/or premiums while an **EMPLOYEE** is on approved medical leave in accordance with **FMLA**, reinstatement will be immediate providing the **EMPLOYEE** returns to work immediately following or prior to the end of the approved family medical leave. Provisions of the **PLAN** will be applied if there is no lapse in coverage.

   An **EMPLOYEE** who returns from Reservist Active Military status will be reinstated immediately upon return to **ACTIVE SERVICE** in accordance with the requirements of **USERRA**.

   A laid off **EMPLOYEE** who has had no lapse in coverage will be reinstated on the first day he returns to **ACTIVE SERVICE**. A laid off **EMPLOYEE** who has had a lapse in coverage must meet the **WAITING PERIOD** as if they were a new hire.

   OPEN ENROLLMENT PERIOD: The month of December for a January 1st **EFFECTIVE DATE**.
3. TERMINATION DATE: Termination will occur on the day following the last day of the month of termination of **ACTIVE SERVICE** at 12:01 a.m., or after three (3) months of approved medical leave for the **EMPLOYEE** provided the **EMPLOYEE** qualifies for the **EMPLOYER** allowed sick days and/or leave, or after twelve (12) weeks of approved family leave per **PLAN YEAR** in accordance with the Family Medical Leave Act of 1993 (FMLA), or after worker's compensation extension required by individual state statute if applicable, has been exhausted. The **COVERED EMPLOYEE** may have a responsibility to notify the **PLAN ADMINISTRATOR** of certain changes in a **COVERED DEPENDENTS** status. See **CONTINUATION OF COVERAGE** Section on notification. If a **COVERED DEPENDENT** would otherwise lose coverage due to a Qualifying Event, he will remain covered by the **PLAN** until the end of the month during which he has the Qualifying Event.
4. **DEPENDENT CHILD** age limitation: The end of the month in which he reaches 26. If a **COVERED DEPENDENT** reaches the age of twenty-six (26), is medically or physically incapable of supporting himself and relies on the **COVERED EMPLOYEE** for support, coverage may be extended in accordance with the requirements outlined in the definition of a **DEPENDENT**, number 4.
5. Special Enrollment for Previously Enrolled **COVERED PERSONS**: See **ELIGIBILITY REQUIREMENTS**.
6. **RETIREES**: Previous fulltime employees of the City of Burlington that meet the retirement qualifications set by employer. Retirees under age 65 qualify for full coverage, the plan is primary payor. Retirees over age 65 qualify for the supplemental Plan, the plan is secondary.

Refer to ELIGIBILITY REQUIREMENTS section and GENERAL CLAIM PROVISIONS.

CITY OF BURLINGTON

Effective Date: JANUARY 1, 2015

This Schedule of Benefits is only a summary of your medical and must be used in conjunction with the limitations and restrictions outlined in the Document/Summary Description. Note only medically necessary services will be considered at the reasonable and customary and/or negotiated fee.

CALENDAR YEAR DEDUCTIBLES	**Preferred Provider Network**	**Non Preferred Provider Network**
• Individual Deductible	$ 200	$ 500
• Family Deductible	$ 400	$1,000
CALENDAR YEAR OUT-OF- POCKET LIMITS		
• Individual Out-of-Pocket Limit	$ 600	$1,500
• Family Out-of-Pocket Limit	$ 1,200	$2,000

The Preferred Provider and Non-Preferred Provider **DEDUCTIBLES** and **COINSURANCES** accumulate separately. Calendar Year out-of-pocket limits include **DEDUCTIBLE** and **COINSURANCE** but not penalties.

MAXIMUM CALENDAR YEAR OUT-OF- POCKET LIMITS		
• Individual Out-of-Pocket Limit	$ 5,350	N/A
• Two-Person/Family Out-of-Pocket Limit	$11,000	N/A

Maximum Calendar Year out-of-pocket limits include Medical **DEDUCTIBLE**, **COINSURANCE** and copayments but not penalties. When the **YEAR** out-of-pocket limit is met by a **COVERED PERSON**/family, medical claims incurred for the remainder of that **YEAR** will pay at 100% less applicable penalties or usual and customary charges. When the Overall Calendar Year out-of-pocket limit is met by a COVERED PERSON/family, medical and prescription claims incurred for the remainder of the **YEAR** will pay at 100% with no copayments less applicable penalties or usual and customary charges.

Total Care Inpatient Pre-Certification – To certify Inpatient call 877-840-7341

- Pre-Certification required for all Inpatient **HOSPITAL** confinements or within 48 hours of an Emergency Admission for Hospital Admission, Extended Hospital Stay, Confinement in Extended Care Facility and Skilled Nursing Facility. Admissions for maternity are excluded unless the **COVERED PERSON** remains in-patient for more than 48 hours for a normal delivery or 96 hours for a C-section.

Individual Annual Maximum **Unlimited**

PRESCRIPTION BENEFITS – Maximum out of pocket copayments $1,250/Individual and $2,500/Two-Person or Family per calendar year.

PHARMACY OPTION – 90 day supply through a participating Pharmacy

Generic Drugs	$10 copayment
Brand Drugs*	$15 copayment

*Copay is $10 if a generic drug is not available

MAIL ORDER OPTION – 90 day supply through MaxorPlus

Generic Drugs	$20 copayment
Brand Drugs*	$30 copayment
Split Incentive	$0

*Copay is $20 if a generic drug is not available

Maxor may be contacted at **1-800-687-8629**

This allows coverage for contraceptives, diabetic drugs & supplies and smoking cessation-both prescription and OTC @ 100% - no copayments. Prescriptions mandated under ACA are covered with no copayment. Other covered or excluded drugs are in the Document. The formulary for Preferred Brand Drugs is available at www.maxorplus.com

Schedule of Benefits

*** Indicates percentage payable after payment of Calendar Year Deductible.**
All Maximums shown indicate Year or Calendar Year Maximum per Individual.

	PPO	Non-PPO	Maximums
Inpatient Hospital Expenses			
General Medical Room & Board	80%*	70%*	Pre-certification Required
Maternity	80%*	70%*	Pre-certification required for inpatient over 48 hours for normal delivery or 96 hours for C-section
Newborn Care	80%*	70%*	
Surgery (In-Patient)	80%*	70%*	Pre-certification Required
Miscellaneous Hospital Charges	80%*	70%*	Pre-certification Required
Mental Health or Substance Abuse	80%*	70%*	Pre-certification Required
Extended Care Expenses			
In-Patient Extended Care Facility/ Skilled Nursing Facility/	80%*	70%*	Pre-certification Required
Rehabilitation Hospital	80%*	not covered	Pre-certification Required
Hospice Home Care	80%*	70%*	
Hospice In or Out Patient Care	80%*	70%*	Inpatient Pre-certification Required
Home Health Care	80%*	70%*	
Home Health Care includes nursing, home health aide & covered therapies. Must be performed by a Home Care Agency.			
Private Duty Nursing	80%*	70%*	Maximum 100 hours per calendar year
Outpatient Hospital Expenses **(When a hospital bills for the services)**			
Pre-admission Testing	80%*	70%*	
Ambulatory Surgery	80%*	70%*	Includes all services on day of surgery
Surgical Facility/Services	80%*	70%*	Includes Birthing Centers
Diagnostic Lab	80%*	70%*	
Diagnostic X-Ray & Imaging	80%*	70%*	
Cardiac Rehabilitation/Therapy	80%*	not covered	36 sessions/Cardiac-Event
Other Outpatient Hospital Services	80%*	70%*	
Emergency Room Care **(Hospital Charges only)**			
Medical Emergency	80%*	70%*	
Non-Medical Emergency	Not Covered	Not Covered	
Urgent Care Center	$10 copayment then 100%	$10 copayment then 100%	
Inpatient Hospital Physician Expenses **(Physician's charges to treat an inpatient)**			
Anesthesia while Inpatient	80%*	70%*	
General Conditions	80%*	70%*	
Surgery	80%*	70%*	
Maternity and Newborn Care	80%*	70%*	

Outpatient Hospital	**PPO**	**Non-PPO**	**Maximums**
Physician Expenses (Physician's charges to treat an outpatient)			
Ambulatory Services	80%*	70%*	
Emergency Room	$10 copayment then 100%	70%*	
Physician Expenses	80%*	70%*	
Physician Expenses Clinic Fee	80%*	70%*	
Physician Office Expenses			
Allergy Injections	$10 copayment then 100%	70%*	if billed with an office visit only 1 office visit copay will apply
Allergy Testing	80%*	70%*	
Chemotherapy	80%*	70%*	
Diagnostic Lab	80%*	70%*	
Diagnostic X-Ray & Imaging	80%*	70%*	
Maternity	80%*	70%*	
Maternity-Dependent Child	80%*	70%*	
Office Visits	$10 copayment then 100%	70%*	includes all office visits
Office Surgery	$10 copayment then 100%	70%*	if billed with an office visit only 1 office visit copay will apply
Radiation Therapy Visit	80%*	70%*	
Second / Third Surgical Opinion	$10 copayment then 100%	70%*	
Wellness Expenses (Includes standard routine lab and x-ray charges as well as HPV, DNA and HIV)			
Routine Well Child Care	100%	70%*	Includes hearing test
Routine Physical (Well Woman) Exam	100%	70%*	One per Calendar Year
Routine GYN Exam	100%	70%*	One per Calendar Year
Immunizations – Routine/Preventive	100%	70%*	Well Child & Adult
Routine/Preventive Pap Smear	100%	70%*	One per Calendar Year
Routine/Preventive Mammograms	100%	70%*	One per Calendar Year
Annual Prostate exam & PSA Testing	100%	70%*	One per Calendar Year
Colonoscopy-Screening	100%	70%*	Follow ACS Guidelines
Breast Feeding/Support/Supplies/Counsel	100%	100%	Includes lactation and breast pumps
Counseling & Screening for the following will be covered:			
Gestational Diabetes	100%	70%*	
Sexually Transmitted Infections / HIV	100%	70%*	
Interpersonal & Domestic Violence	100%	70%*	
Contraception	100%	70%*	
Tobacco Cessation	100%	70%*	

Wellness Expenses use the guidelines required by the United States Preventive Services Task Force as amended from time to time.

Schedule of Benefits

	PPO	Non-PPO	Maximums
MOM's Program (see plan details)			
Skilled Nursing	100%	100%	3 visit maximum within 60 days after delivery
Educational Classes – childbirth, sibling, parenting & CPR	100%	100%	Maximum of $125
Homemakers Service*	100%	100%	Up to $25 maximum & 9 hour maximum. Services eligible with a provider as defined by the Plan.
Fitness Classes*	100%	100%	Maximum $150 for classes during pregnancy or within 3 months of birth
Car Seat*	100%	100%	Maximum $150 purchased during pregnancy or within 3 months of birth
*Choice of only one if enrolled in MOM's Program prior to 34 weeks.			
Other Medical Expenses			
Acupuncture	100%	100%	
Ambulance Transportation	80%*	80%*	Emergency & routine transport. Non-emergency requires prior approval.
Anesthesia	80%*	70%*	
Birthing Center	80%*	70%*	
Chiropractic Services	$10 copayment then 100%	70%*	Allows up to 12 visits per year. Prior approval is required for visits in excess of 12 per year.
Contraceptive Services	100%	70%*	Includes injectables, implantable devices
Dental Surgical Treatment	80%*	70%*	
Dialysis	Covered	Covered	Claims pay based on service rendered
Diagnostic Lab	80%*	70%*	
Diagnostic X-Ray & Imaging	80%*	70%*	
Durable Medical Equipment	80%*	70%*	
Genetic Testing & Counseling	Limited Services requiring Prior Approval		
Infertility Testing	80%*	70%*	
Infertility Treatment	Not Covered	Not Covered	
Medical Supplies	80%*	70%*	
Nutritional Counseling	$10 copayment then 100%	not covered	3 visit maximum per year. Visits for Diabetes do not count towards this maximum
Organ Transplants	Covered	Covered	Prior Approval Required
Physical, Speech, Occupational Therapy Illness combined	80%*	70%*	
All therapies combine to a maximum of 30 visits per Year. Coverage for Developmental Delays are covered up to age 3.			
Prosthesis	80%*	70%*	
TMJ Treatment	80%*	70%*	
Voluntary Sterilization	100%	70%*	

	PPO	Non-PPO	Maximums
Vision Expenses (Routine)			
Vision Exam-Routine	$10 copayment	$10 copayment	Age 19 & over limited 1 exam per Year
Vision Exam-Routine	100%	100%	Up to age 19 limited 1 exam per Year
Vision Hardware	Not Covered	Not Covered	Age 19 & over through VSP Plan
Vision Hardware – glasses & frames or contacts	100%	100%	Up to age 19

Primary Care Providers

A current list of PPO providers is available, without charge, through the Third Party Administrator's website, located at www.mygisc.com Go to the "Find a Provider" section on our website, choose the PPO listed in the "How to File a Claim Section" of this booklet.

Each **COVERED PERSON** has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The **COVERED PERSON**, together with his or her **PHYSICIAN**, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the **PLAN** will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the **PLAN** nor the **PLAN ADMINISTRATOR** make any warranty as to the quality of care that may be rendered by any PPO provider.

This Schedule of Benefits only highlights your Group Medical Benefits. Please refer to the following for a complete description of your benefits.

- **How To Select A Preferred Provider**

  Select a provider from the List of Participating Providers which may be obtained from the **EMPLOYER**, by calling the Network or through the Internet. "Participating Providers" are **PHYSICIANS**, **HOSPITALS**, and other health care professionals who are bound by contract to accept, as full payment, the co-payment and payment by this **PLAN**, as stated in the SCHEDULE OF BENEFITS (unless you have exceeded the limits as stated in the SCHEDULE OF BENEFITS). **COVERED PROVIDERS** may join or leave Networks at anytime. It is the responsibility of the **COVERED PERSON** to verify that a **COVERED PROVIDER** is in Network at the time a service is rendered. This can be done with the Provider or the Network.

- **Primary Care Providers**

  A current list of PPO providers is available, without charge, through the Third Party Administrator's website, located at www.giscinc.com. Go to the "Find a Provider" section on our website and choose the PPO listed in the "How to File a Claim Section" of this booklet.

  Each **COVERED PERSON** has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The **COVERED PERSON**, together with his or her **PHYSICIAN**, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the **PLAN** will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the **PLAN** nor the **PLAN ADMINISTRATOR** make any warranty as to the quality of care that may be rendered by any PPO provider.

- **The In-Network Benefits Will Apply To:**

  Charges by a non-participating **PHYSICIAN** referred to the **COVERED PERSON** by a participating **PHYSICIAN.** A letter from the participating **PHYSICIAN** will be required.

  Charges by a non-participating **PHYSICIAN** on-call during the absence of the participating **PHYSICIAN**.

- **Related MEDICALLY NECESSARY Expenses**

  Charges by a non-participating Provider affiliated with a Network **HOSPITAL** (Anesthesiologist, Radiologist, Emergency Room **PHYSICIAN** and Pathologist) will be considered at the In-Network level of benefits. If treated by a Network **PHYSICIAN**, all related lab and X-ray charges shall also be considered as In-Network expenses.

  Note: Expenses incurred by **COVERED PERSONS** living or traveling outside of the network geographic area will be considered at the in-network level of benefits unless such persons are living or traveling in an area where the Cigna network is available. In this situation, Cigna providers must be utilized or benefits will pay at the Out-of-Network level.

  From time to time, non-network claims may be negotiated and paid at the In-Network level of benefits. This is usually at the discretion of the **PLAN**.

Hospital Pre-Admission Certification Benefit

Under this **PLAN**, all non-**EMERGENCY HOSPITAL** admissions to any **HOSPITAL** must be pre-certified by calling **GISC TOTALCARE**.

You or your **PHYSICIAN** must notify **GISC TOTALCARE** prior to admission in any **HOSPITAL** by calling the toll-free telephone number listed below and on your ID card. You must also notify your **PHYSICIAN** of this requirement. ***It is your responsibility to confirm that pre-certification has been completed.***

In the case of **EMERGENCY** admissions to any **HOSPITAL**, it is the responsibility of the **PHYSICIAN**, patient, or patient's family to contact **GISC TOTALCARE** within twenty-four (24) hours of admission or by the next business day if admission occurs over a weekend.

By accepting participation in the **PLAN** all **COVERED PERSONS** agree and consent to the disclosure of your medical records for purposes of the **GISC TOTALCARE** Program.

HOSPITAL Pre-Certification:

GISC TOTALCARE
Administered by
CIGNA

Call Toll Free

Providers & Members: 800-242-4472

Refer to Claims Procedure Section to appeal any days not certified.

Failure to obtain pre-approval may result in a denial of benefits if services are determined to be not **MEDICALLY NECESSARY** as defined by the **PLAN**.

Note: The **PROVIDER** is not responsible for making the required call.

How to File
A Claim

- **How A Preferred Provider Claim Is Filed**

  1. Present your I.D. Card with your signature and provide your ID number to the **PREFERRED PROVIDER** prior to services being rendered or items purchased.

  2. All billings will be handled directly between the provider, the **PREFERRED PROVIDER** company, and Group Insurance Service Center, Inc. If you receive a bill from the provider and it does not indicate that the bill was filed to Group Insurance Service Center Inc., please contact the provider and direct them to file the claim to Group Insurance Service Center Inc. You may also send your copy of the bill that you received at home to Group Insurance Service Center, Inc. when a **PREFERRED PROVIDER** is used.

- **When Not Using a Preferred Provider**

  It is the **COVERED PERSON'S** responsibility to see that itemized **HOSPITAL** charges, doctor/dentist bills, and all medical bills are sent to the **PLAN SUPERVISOR**.

  FOR PROMPT CLAIMS PAYMENT BE SURE TO INCLUDE THE FOLLOWING ITEMS:

  1. **EMPLOYEE'S** name, ID number on the ID card, home address and birth date.
  2. If claim is related to an **INJURY** please advise how, when and where the **INJURY** occurred.
  3. If claim is on a **DEPENDENT**: his name, birth date, and employer, and name of any other group health coverage.
  4. **EMPLOYER** name.
  5. All **HOSPITAL** bills and other medical bills should include:
     a. name of patient,
     b. diagnosis,
     c. itemization of charges with dates for each service and procedure codes,
     d. name, address and Federal Tax Identification number of the provider.
  6. Prescription Drug claims should include:
     a. name of patient,
     b. name of drug,
     c. date of purchase, prescription number and charge for each drug.

  If necessary, obtain a medical claim form from your benefits department or at www.giscinc.com and completely fill out the front of the claim form. Benefits are automatically assigned and paid to the **HOSPITAL**, **PHYSICIAN** or dentist by the **PLAN SUPERVISOR**. Please be sure to read the "CERTIFICATION & AUTHORIZATION," then date and sign where indicated on the bottom of the front of the claim form.

  A listing of medical providers who participate in the Preferred Provider Network may be provided upon request through your employer or you may access this list on the Internet at www.mygisc.com and click on the members tab, then "Find a Provider".

Certain words and phrases used in this Plan Document are listed below, along with the definition and explanation of how the term is used for the purposes of this **PLAN**.

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

Wherever any words are herein used in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply. ***The fact that a term is defined does not constitute coverage.***

Active Service For the purposes of this **PLAN** an **ELIGIBLE EMPLOYEE** will be considered in **ACTIVE SERVICE** on a day which is a scheduled work day if he is performing in the customary manner all of the regular duties of his employment either at his customary place of employment or at some location at which that employment requires him to travel, or if he is absent from work by reason of vacation, jury duty, personal day, holiday, less than 3 consecutive sick days on an approved medical leave of absence, or an approved leave under the **FMLA**.

Administrative Period for 4980H Eligibility For the purposes of this **PLAN** shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days.

Affiliated For the purposes of this **PLAN** shall mean facilities that have connections as a member or a branch.

Allowable Expenses For the purposes of this **PLAN** shall mean the **USUAL AND CUSTOMARY** charge for any **MEDICALLY NECESSARY, REASONABLE e**ligible item of expense, at least a portion of which is covered under this **PLAN**.

In the case of HMO (Health Maintenance Organization) plans, this **PLAN** will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the **COVERED PERSON** does not use an HMO Provider, this **PLAN** will not consider as Allowable Expenses any charge that would have been covered by the HMO had the **COVERED PERSO**N used the services of an HMO Provider.

Ambulatory Surgical Center For the purposes of this **PLAN** shall mean a licensed institution, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and discharged from within a twenty-four (24) hour period.

Amendment For the purposes of this **PLAN** shall mean a formal document that changes the provision of this **PLAN**, duly signed by the authorized person or persons as designated by the **EMPLOYER/PLAN SPONSOR.**

Approved Clinical Trials For the purposes of this **PLAN** shall mean a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening **ILLNESS** or **INJURY**, as defined under the ACA, provided:

a. The clinical trial is approved by:
   i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
   ii. The National Institute of Health;
   iii. The U.S. Food and Drug Administration;
   iv. The U.S. Department of Defense;
   v. The U.S. Department of Veterans Affairs; or

Approved Clinical Trials (cont'd)

vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Assignment of Benefits For the purposes of this **PLAN** shall mean an arrangement whereby the **COVERED PERSON** assigns their right to seek and receive payment of eligible **PLAN** benefits, in strict accordance with the terms of this **PLAN** Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive **PLAN** benefits are equal to those of a **COVERED PERSON**, and are limited by the terms of this Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Birthing Center For the purposes of this **PLAN** shall mean a licensed facility operated by a **HOSPITAL** or other licensed health care facility for the purpose of providing an alternative environment for childbirth other than the **HOSPITAL** delivery or operating room.

Calendar Year For the purposes of this **PLAN** shall mean a period of time commencing on January 1 and ending on December 31 of the same given year.

Chemical Dependency/ Substance Abuse Treatment Facility

For the purposes of this **PLAN** shall mean a licensed residential or non-residential detoxification facility, or licensed **SUBSTANCE ABUSE TREATMENT FACILITY** which provides continuous structured programs for inpatient and outpatient treatment and rehabilitation for chemical dependency and substance abuse. The facilities must be licensed in the political jurisdiction in which it operates.

Child For the purposes of this **PLAN** shall mean, in addition to the **EMPLOYEE**'s own blood descendant of the first degree or lawfully adopted **CHILD**, a **CHILD** placed with a covered **EMPLOYEE** in anticipation of adoption, a covered **EMPLOYEE**'s **CHILD** who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other **CHILD** for whom the **EMPLOYEE** has obtained legal guardianship.

CHILD may also include any blood descendant of the first degree or legally adopted **CHILD** of a Domestic Partner.

CHIPRA For the purposes of this **PLAN** shall mean the Children's Health Insurance Program Reauthorization Act of 2009 which creates two new special enrollment period rights: 1) termination of Medicaid or Children's Health Insurance Coverage due to loss of eligibility; 2) obtaining eligibility for a State premium assistance subsidy under these programs. Coverage will be effective the first of the month after the **PLAN** receives the request for special enrollment **and** proof of loss of eligibility/subsidy.

Claim For the purposes of this **PLAN** is any request for a **PLAN** benefit or benefits, made by a **COVERED PERSON** or by a representative of a **COVERED PERSON**, including a request for coverage determination, pre-authorization or approval of a benefit.

Clean Claim

For the purposes of this **PLAN** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A **CLEAN CLAIM** does not include claims under investigation for fraud and abuse or claims under review for **MEDICAL NECESSITY** and **REASONABLENESS**, or fees under review for **USUAL AND CUSTOMARINESS**, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a **CLEAN CLAIM**. A Provider submits a **CLEAN CLAIM** by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The **PLAN ADMINISTRATOR** may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a **CLEAN CLAIM** if the **COVERED PERSON** has failed to submit required forms or additional information to the **PLAN** as well.

Co-Insurance

For the purposes of this **PLAN** shall mean the percentages shown in the SCHEDULE OF BENEFITS used to figure the amount of **COVERED EXPENSES** considered under this **PLAN**.

Continuation of Coverage

For the purposes of this **PLAN** shall mean the extension of health care coverage provided at the expense of the Qualified Beneficiary and required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any related amendments. Refer to CONTINUATION OF COVERAGE SECTION.

Cosmetic Surgery

For the purposes of this **PLAN** shall mean a procedure performed for the improvement of a **COVERED PERSON'S** appearance and which is not **MEDICALLY NECESSARY**.

Covered Dependent

For the purposes of this **PLAN** shall mean a **CHILD** or spouse or Domestic Partner and his natural children of a **COVERED EMPLOYEE** who has met all of the **DEPENDENT** eligibility requirements and has been approved for coverage under this **PLAN**.

Covered Employee

For the purposes of this **PLAN** shall mean an **ELIGIBLE EMPLOYEE** who has been approved for coverage under this **PLAN**.

Covered Expenses

For the purposes of this **PLAN** means a **USUAL AND CUSTOMARY** fee for a **REASONABLE**, **MEDICALLY NECESSARY** service, treatment or supply, meant to improve a condition or **COVERED PERSON**'s health, which is eligible for coverage in this **PLAN**. **COVERED EXPENSES** will be determined based upon all other **PLAN** provisions

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document.

Covered Person

For the purposes of this **PLAN** shall mean any **COVERED EMPLOYEE**, **COVERED DEPENDENT**, **RETIREE** or Qualified Beneficiary under CONTINUATION OF COVERAGE.

Covered Provider

1. For the purposes of this **PLAN** the following providers are eligible for consideration under this **PLAN** as long as they are licensed or certified in the political jurisdiction where practicing if applicable, and are acting within the scope of that license:

- Acupuncturist
- Ambulance
- **AMBULATORY SURGICAL CENTER**
- **BIRTHING CENTER**
- Certified Alcohol Counselor
- Certified Mental Health Counselor
- Certified or Licensed ABA Therapist
- Certified Registered Nurse Anesthetist
- **CHEMICAL DEPENDENCY TREATMENT FACILITY**
- Chiropractor (D.C.)
- Clinic
- Dentist (DDS or DMD)
- Detoxification Facility
- **HOSPICE**
- **HOSPITAL**
- Laboratory
- Licensed Clinical **SOCIAL WORKER**
- Midwife or, Certified Nurse Midwife
- Naturopath
- Nurse Practitioner
- Optometrist
- Pharmacist
- **PHYSICIAN**
- **PHYSICIAN'S** Assistant
- Podiatrist (D.P.M.)
- Psychiatrist
- **PSYCHOLOGIST** (Ph.D.)
- **SOCIAL WORKER** (M.S.W.)

2. The following providers are eligible for consideration under this **PLAN** as long as the attending **PHYSICIAN** has ordered the care, treatment or supply and the provider is licensed, registered or certified in the political jurisdiction where practicing (if applicable) and are acting within the scope of that license. A copy of the **PHYSICIAN**'S orders may be required:

- **EXTENDED CARE FACILITY/ SKILLED NURSING FACILITY/ REHABILITATION FACILITY**
- **HOME HEALTH AGENCY**
- Licensed Audiologist
- Licensed Occupational Therapist
- **LICENSED PRACTICAL NURSE**
- Licensed Speech Therapist
- Medical Supply Purveyor
- Registered Dietician
- **REGISTERED NURSE**
- Registered/Licensed Physical Therapist
- Visiting Nurse Association

3. Non Physicians

Non physician assistants at surgery may be covered when they are certified by their professional association, licensed in the state where employed, are credentialed by the facility to assist with procedure, are performing a service that would otherwise be performed by a **PHYSICIAN** and are performing a procedure which allows an assistant at surgery.

A **COVERED PROVIDER** will not include the **EMPLOYEE**, his spouse, children, brothers, sisters, or parents nor any other person residing in his household.

Note: The fact that a **PROVIDER** is listed does not guarantee services are covered by the **PLAN.**

Custodial Care

For the purposes of this **PLAN** shall mean the provision of **ROOM AND BOARD**, routine nursing care, training in personal hygiene and other forms of self-care, or supervisory care by a **PHYSICIAN**, for a person who is mentally or physically disabled as a result of retarded development or bodily infirmity. This person is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing medical care or, to return to **ACTIVE SERVICE**.

Deductible

For the purposes of this **PLAN** shall mean the dollar amount of **COVERED EXPENSES** in the SCHEDULE OF BENEFITS that each **COVERED PERSON** will owe in a **CALENDAR YEAR** before **PLAN** payments are made.

Dependent

For the purposes of this **PLAN** shall mean the following, as long as the **DEPENDENT** has and provides a valid social security number. In lieu of, as long as the **DEPENDENT** is eligible according to the Medical Secondary Payer Mandatory Reporting Provisions, included but not limited to having a Social Security number or any other identifier that meets the requirements.

1. The **COVERED EMPLOYEE'S** legal spouse who is a legal resident of the same country in which the **COVERED EMPLOYEE** resides. Such spouse must have met all requirements of a valid marriage contract in that political jurisdiction.

   The **COVERED EMPLOYEE'S** Partner who meets all of the following requirements:

   In the states where it is legal, same-sex partnership will be documented and authenticated by marriage; a certificate of marriage will be required to verify marital status, just as it is for heterosexual couples. In states or municipalities where a different union enjoys legal status (such as Civil Unions), equivalent documentation to verify union will be required. And in states where no legal status has been defined, a signed affidavit will be required.

   Since **PLAN** recognizes same-sex partnerships as marital equivalents, it follows that the definition of family will include their eligible dependent children of either partner or of the union. Same-sex partners will, therefore, be eligible for family coverage under our medical plans.

   The **COVERED EMPLOYEE's** Domestic Partner who meets all of the following requirements:

   a. Each party must be the only Domestic Partner of the other;
   b. Each party must be at least 18 years of age and legally competent to enter into a contract in the state where he lives;
   c. The partners must share a common residence and must have shared the residence for at least six (6) months before applying for domestic partnership coverage;
   d. Neither partner may be married;
   e. Neither partner may be related to the other by adoption or blood to a degree of closeness that would bar marriage in the state they reside;
   f. The partners must have a relationship of mutual support, caring and commitment and must intend to remain in such a relationship in the indefinite future;

Dependent (Continued)

g. The partners must be jointly responsible for basic living expenses, such as cost of basic food, shelter and any other expenses of the common household. The partners need not contribute equally as long as they agree that both are responsible;

h. Neither partner may have filed a termination of Domestic Partnership within nine months before he applies for coverage;

i. Proof of common residence and financial interdependence must be provided;

j. Statement of Domestic Partnership must be completed and approved.

2. A **CHILD** of the **COVERED EMPLOYEE** between the ages of birth and the end of the month in which he turns 26.
   A. The term "**CHILD**" shall include a natural born **CHILD**, adopted **CHILD**, a **CHILD** in the probationary period for adoption, stepchild, a natural born **CHILD** of a Domestic Partner and a **CHILD** for whom the **COVERED EMPLOYEE** has legal guardianship (proof will be required) or be the subject of a **QUALIFIED MEDICAL CHILD SUPPORT ORDER**. In the case of divorce, where the decree assigns the parent with custody and/or determines the party who provides medical coverage, providing the decree is being followed, it will supercede the above.
   B. An adult **CHILD** of a **COVERED EMPLOYEE** under the age of 26.

3. A **CHILD** of the **COVERED EMPLOYEE** between the date of birth and the end of the month in which he turns 26. Under the **PLAN**, no **CHILD** may be considered a **DEPENDENT** (except for COBRA rights) after the 26th birthday. This restriction of coverage applies to all children, excluding those who are fully disabled. Due to PPACA, a **CHILD** need not be a tax dependent or a full-time student to be covered as a **DEPENDENT**.

4. A **CHILD** of a **COVERED EMPLOYEE** covered by this **PLAN** on his 26th birthday and who is incapable of self-sustaining employment by reason of mental retardation or physical disability, principally dependent upon the **COVERED EMPLOYEE** for support and maintenance may apply to extend coverage. Proof of such incapacity and dependency must be furnished to the **PLAN ADMINISTRATOR** by the **COVERED EMPLOYEE** within 30 days of the **CHILD**'s 26th birthday or initial eligibility. The **PLAN ADMINISTRATOR**, or its designee, will approve or deny coverage under this **PLAN** based on satisfactory proof of incapacity and dependency. The **PLAN ADMINISTRATOR** may require, at reasonable intervals during the two years following the **CHILD**'s 26th birthday, subsequent proof of the **CHILD**'s disability and dependency. After such two year period, the **PLAN ADMINISTRATOR** may require subsequent proof not more than once each year. The **PLAN ADMINISTRATOR** has the right to have such **CHILD** examined by a **PHYSICIAN** of the **PLAN ADMINISTRATOR'S** choice to determine the existence of such incapacity.

5. If a **COVERED EMPLOYEE** acquires a newborn **CHILD**, stepchild, a newly adopted **CHILD**, a **CHILD** for whom the **COVERED EMPLOYEE** is the legal guardian or a new spouse, or Domestic Partner and his natural children, adopted children or children for whom the Domestic Partner has assumed legal guardianship, such **DEPENDENT** will become eligible for coverage under this **PLAN** on the date he is acquired by the **COVERED EMPLOYEE** provided such **DEPENDENT** is enrolled in this **PLAN** within 30 days from the date he is acquired and have provided satisfactory proof of dependency or a **QUALIFIED MEDICAL CHILD SUPPORT ORDER**. For **COVERED EMPLOYEE**S who previously waived **DEPENDENT** coverage, this immediate enrollment of newly-acquired **DEPENDENT** will apply on the newly acquired **DEPENDENT** only.

Dependent (Continued)

All other **DEPENDENT**S of the **COVERED EMPLOYEE**, if **DEPENDENT** coverage was previously declined, will not become eligible to be enrolled in this **PLAN** unless they may apply under the **SPECIAL ENROLLMENT PROVISION** or at **OPEN ENROLLMENT**.

6. A **CHILD** of a divorced **COVERED EMPLOYEE** becomes eligible for benefits based on the terms outlined in the **COORDINATION OF BENEFITS** SECTION. This **CHILD** need not be claimed as a **DEPENDENT** on the **COVERED EMPLOYEE'S** federal income tax return.

   Excluded as a **DEPENDENT** under 1, 2, 3, 4, 5 and 6 above is:

   1. A Person legally separated or divorced from the **COVERED EMPLOYEE**;
   2. Any person(s) while in any military service of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in total in any **CALENDAR YEAR**; and

If both parents are covered under this **PLAN** as an **EMPLOYEE**, both may cover their **ELIGIBLE DEPENDENT** children as **DEPENDENT**S under this **PLAN**.

Durable Medical Equipment

For the purposes of this **PLAN** shall mean equipment which is able to withstand repeated uses; primarily and customarily used to serve a medical purpose; and not generally useful to a person in the absence of **ILLNESS** or **INJURY**.

Early Intervention Services

For the purposes of this **PLAN** shall mean physical, speech/language and occupational therapy, nursing care and psychological counseling provided to a **DEPENDENT** from birth to age three (3). Refer to the Schedule of Benefits for coverage

Effective Date

For the purposes of this **PLAN** refer to SUMMARY PLAN INFORMATION SECTION.

Elective Surgical Procedures

For the purposes of this **PLAN** shall mean a non-emergency surgical procedure that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

Eligible Dependent

For the purposes of this **PLAN** shall mean the **CHILD** or spouse (or Domestic Partner and his natural children) of an **ELIGIBLE EMPLOYEE** who meets the **DEPENDENT ELIGIBILITY REQUIREMENTS** and the **ELIGIBLE EMPLOYEE** has completed an enrollment card within the thirty (30) days following the **WAITING PERIOD**. In addition, all **ELIGIBLE DEPENDENTS** must provide a valid social security number or identifier that complies with the MSPMRP guidelines upon enrollment .

Eligible Employee

For the purposes of this **PLAN** shall mean an **EMPLOYEE** who meets the following: **WAITING PERIOD** as stated on the SUMMARY PLAN INFORMATION SECTION; the **ELIGIBILITY REQUIREMENTS** and the filing of a completed enrollment card, or has a **SPECIAL ENROLLMENT EVENT**. In addition, all **ELIGIBLE EMPLOYEES** must provide a valid social security number or identifier that complies with the MSPMRP guidelines upon enrollment.

Eligible Person

For the purposes of this **PLAN** shall mean any **ELIGIBLE EMPLOYEE** and **ELIGIBLE DEPENDENT**.

Emergency For the purposes of this **PLAN** shall mean the sudden onset of a medical or dental condition of sufficient severity that it requires immediate medical or dental attention. It is a condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Condition For the purposes of this **PLAN** shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn **CHILD**) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Emergency Services For the purposes of this **PLAN** shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the **HOSPITAL**, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Essential Health Benefits For the purposes of this **PLAN** shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; **EMERGENCY SERVICES**; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Employee For the purposes of this **PLAN** shall mean all persons working for the **EMPLOYER** as stated on the SUMMARY PLAN INFORMATION SECTION and the Eligibility Section.

Employee for 4980H Eligibility For the purposes of this **PLAN** shall mean a person who is a regular full time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work at least twenty (20) hours per week in order to be considered "full time."

"Employee" shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work at least twenty (20) hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least twenty (20) hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

Employer For the purposes of this **PLAN** shall mean City of Burlington.

Enrollment Date For the purposes of this **PLAN** shall mean the first day of coverage under this **PLAN** or, if there is a **WAITING PERIOD**, the first day of the **WAITING PERIOD** as defined by **HIPAA** which is your date of hire.

Expenses Incurred For the purposes of this **PLAN** shall mean that a covered expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Experimental / Investigative Treatment For the purposes of this **PLAN,** and unless stated elsewhere, shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The **PLAN ADMINISTRATOR** retains maximum legal authority and discretion to determine what is experimental.

Extended Care / Skilled Nursing/ Rehabilitation Facility

For the purposes of this **PLAN** shall mean an institution, or a distinct part thereof, which is licensed pursuant to state and local laws, is approved by **MEDICARE** and is operated primarily for the purpose of providing **SKILLED NURSING CARE** and treatment for individuals convalescing from **INJURY** or **ILLNESS** and

1. Has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a **PHYSICIAN** or **REGISTERED NURSE**; and
2. Maintains daily clinical records on each patient, has an effective utilization review program and has available the services of a **PHYSICIAN** under an established agreement; and
3. Provides appropriate methods of dispensing and administering drugs and medicines; and
4. Has transfer arrangements with one or more **HOSPITAL**S; and
5. Excludes any institution which is primarily a rest home, a home for the aged, or a place for treatment of mental disease, drug addiction or alcoholism.

FMLA

For the purposes of this **PLAN** shall mean the **FAMILY AND MEDICAL LEAVE ACT** of 1993, Public Law 103-3, 107 Stat.6 (29 U.S.C. 2601 et, seq.), as may be amended from time to time. In addition, military family leave entitlements enacted under the National Defense Authorization Act will apply. The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. FMLA is granted during the **PLAN ADMINISTRATORS PLAN YEAR**, July 1sth to June 30th. During FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

Fulltime Employee or Fulltime Employment for 4980H Eligibility

For the purposes of this **PLAN** shall mean with respect to a calendar month, an Employee who is employed an average of at least 20 hours of service per week with the Employer.

GISC TotalCare

For the purposes of this **PLAN** shall mean programs providing Case Management, Peer Review, In-Patient Pre-Certification, Maternity Management, Wellness, and CallMD.

Habilitative Services

For the purposes of this **PLAN** shall mean a habilitative service is a health service that allows a **COVERED PERSON** to acquire a functional skill that should be present but is absent due to **ILLNESS** or **INJURY** (for example: speech therapy for a non-verbal child with autism).

HIPAA

For the purposes of this **PLAN** shall mean the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Home Health Agency

For the purposes of this **PLAN** shall mean a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet both of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group affiliated with the agency or organization. This professional group must include at least one **PHYSICIAN** and at least one **REGISTERED NURSE** (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a **PHYSICIAN** or **REGISTERED NURSE**.

Hospice

For the purposes of this **PLAN** shall mean an institution or agency which meets the standards of the National Hospice Organization and applicable licensing requirements in its political jurisdiction.

Hospital For the purposes of this **PLAN** shall mean an institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an inpatient basis; and
2. It is constituted, licensed, and operated in accordance with the laws of the jurisdiction in which it is located which pertain to **HOSPITALS**; and
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an **ILLNESS** or an **INJURY**; and
4. Such treatment is provided under the supervision of **PHYSICIAN**S with continuous twenty-four (24) hour nursing services by **REGISTERED NURSES** (R.N.) or graduate nurses (G.N.); and
5. It is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); and
6. It is a provider of services under **MEDICARE**; and
7. It is not, other than incidentally, a place for rest, a place for the aged or a nursing home.

Shall also include institutions licensed for the treatment of psychiatric problems, chemical dependency, substance abuse or tuberculosis that do not have surgical facilities and/or may not approved by **MEDICARE**, provided that such institution satisfies the definition of **HOSPITAL** in all other respects.

Hour of Service for 4980H Eligibility For the purposes of this **PLAN** shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Illness For the purposes of this **PLAN** shall mean only **ILLNESS** or disease, including mental and nervous disorders, chemical dependency/substance abuse which requires treatment by a **PHYSICIAN** or **COVERED PROVIDER**. For purposes of determining benefits payable, **ILLNESS** shall include pregnancy, childbirth, miscarriage, or complications thereof. A recurrent **ILLNESS** will be considered one **ILLNESS**. Concurrent **ILLNESSES** are totally unrelated.

In-Hospital Miscellaneous Expenses For the purposes of this **PLAN** shall mean the actual charges made by a **HOSPITAL** on its own behalf for services and supplies rendered to the **COVERED PERSON** which are **MEDICALLY NECESSARY** for the treatment of such **COVERED PERSON**. Shall also include professional charges for radiology, pathology and anesthesiology services rendered and ambulance transfer from one facility to another while an inpatient.

Initial Measurement Period for 4980H Eligibility For the purposes of this **PLAN** shall mean for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after 12 months consecutive months of service.

Injury For the purposes of this **PLAN** shall mean a physical condition which is the result of an **INJURY** caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

Late Enrollee For the purposes of this **PLAN** shall mean any **ELIGIBLE EMPLOYEE** who originally refused coverage or did not enroll within the thirty (30) days following completion of the **WAITING PERIOD**. **LATE ENROLLEES** may apply for coverage if they have a **SPECIAL ENROLLMENT EVENT** or at **OPEN ENROLLMENT**.

Licensed Practical Nurse

For the purposes of this **PLAN** shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Maximum Amount or Maximum Allowable Charge

For the purposes of this **PLAN** shall mean the benefit payable for a specific coverage item or benefit under the **PLAN**. Maximum Allowable Charge(s) may be the lesser of:

- The **USUAL AND CUSTOMARY** amount,
- The allowable charge specified under the terms of the **PLAN**,
- The negotiated rate established in a contractual arrangement with a **COVERED PROVIDER**, or
- The actual billed charges for the covered services

The **PLAN** may reimburse the actual charge billed if it is less than the **USUAL AND CUSTOMARY** amount. The **PLAN** has the discretionary authority to decide if a charge is **USUAL AND CUSTOMARY** and for a **MEDICALLY NECESSARY** and Reasonable service.

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

Measurement Period For 4980H eligibility

For the purposes of this **PLAN,** shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

Medically Necessary

For the purposes of this **PLAN,** "Medical Care Necessity", "Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a **PHYSICIAN** exercising prudent clinical judgment provided to a **COVERED PERSON** for the purposes of evaluation, diagnosis or treatment of that **COVERED PERSON**'s **ILLNESS** or **INJURY**. Such services, to be considered **MEDICALLY NECESSARY**, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the **COVERED PERSON**'s **ILLNESS** or **INJURY**. The **MEDICALLY NECESSARY** setting and level of service is that setting and level of service which, considering the **COVERED PERSON**'s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered **MEDICALLY NECESSARY** must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the **COVERED PERSON**'s **ILLNESS** or **INJURY** without adversely affecting the **COVERED PERSON**'s medical condition.

A) It must not be maintenance therapy or maintenance treatment.
B) Its purpose must be to restore health.
C) It must not be primarily custodial in nature.

Medically Necessary (Continued)

D) The **PLAN** reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For **HOSPITAL** stays, this means that acute care as an Inpatient is necessary due to the kind of services the **COVERED PERSON** is receiving or the severity of the **COVERED PERSON**'s condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a **PHYSICIAN** does not mean that it is "**MEDICALLY NECESSARY**." In addition, the fact that certain services are excluded from coverage under this **PLAN** because they are not "**MEDICALLY NECESSARY**" does not mean that any other services are deemed to be "**MEDICALLY NECESSARY**."

To be **MEDICALLY NECESSARY**, all of these criteria must be met. Merely because a **PHYSICIAN** or Dentist recommends, approves, or orders certain care does not mean that it is **MEDICALLY NECESSARY**. The determination of whether a service, supply, or treatment is or is not **MEDICALLY NECESSARY** may include findings of the American Medical Association and the **PLAN ADMINISTRATOR**'s own medical advisors. The **PLAN ADMINISTRATOR** has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review

For the purposes of this **PLAN** is the process by which the **PLAN**, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the **PLAN ADMINISTRATOR** may determine the **MAXIMUM ALLOWABLE CHARGE** according to the medical record review and audit results.

Medicare

For the purposes of this **PLAN** shall mean the Social Security Act, as amended from time to time.

Mental Health Clinic

For the purposes of this **PLAN** shall mean a facility established for the purpose of providing consultations, diagnosis, and treatment in connection with a mental or nervous disorder, and approved by a department in that political jurisdiction or agency having authority over such facilities.

New Employee for 4980H Eligibility

For the purposes of this **PLAN** shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

Non-Variable Hour Employee for 4980H Eligibility

For the purposes of this **PLAN** shall mean an Employee reasonably expected at the time of hire to work 20 or more hours per week.

OBRA 93

For the purposes of this **PLAN** shall mean the Omnibus Budget Reconciliation Act of 1993, Public Law 103-66, as may be amended from time to time.

Ongoing Employee for 4980H Eligibility

For the purposes of this **PLAN** shall mean an **EMPLOYEE** who has been employed by the **EMPLOYER** for at least one complete Measurement Period.

Open Enrollment

For the purposes of this **PLAN** shall mean the period of time indicated in the SUMMARY PLAN INFORMATION PAGE during which **ELIGIBLE EMPLOYEES** and their **ELIGIBLE DEPENDENTS** who failed to enroll within the thirty (30) days following completion of the **WAITING PERIOD** may make application for coverage under this **PLAN**.

Organ Transplant For the purposes of this **PLAN** shall mean the taking of a living organ or tissue from a human body and placing it in another human body. No synthetic or artificial devices shall be considered to be a replacement for a living organ or tissue.

Other Plan For the purposes of this **PLAN** shall include, but is not limited to:

1. Any primary payer besides the **PLAN**;
2. Any other group health plan;
3. Any other coverage or policy covering the **COVERED PERSON**;
4. Any first party insurance through medical payment coverage, personal **INJURY** protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Worker's compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Out of Pocket Maximum For the purposes of this **PLAN** is the maximum amount that the **COVERED PERSON** may be responsible for during a **CALENDAR** year. In no event will **PREFERRED PROVIDER** (network) charges exceed the maximum amount specified by the **PPACA** guidelines. This maximum accumulates with network **DEDUCTIBLE**, coinsurance, medical co-payments and prescription co-payments.

Physician For the purposes of this **PLAN** shall mean a legally licensed Medical Doctor (M.D.), Osteopath (D.O.), Optometrist (O.D.), Ophthalmologist (M.D.), Psychiatrist, or Psychologist (Phd or Eed), provided they are licensed in the political jurisdiction where practicing and are acting within the scope of that license. The term **PHYSICIAN** will not include the **EMPLOYEE**, his spouse, children, brothers, sisters, parents nor any other person residing in the patient's household.

Plan For the purposes of this **PLAN** refers to this document as set forth herein, with all **AMENDMENTS**, supplements, benefits and provisions for payment described herein. This **PLAN** is on file at the **PLAN ADMINISTRATOR**'S office, or at any location of the **EMPLOYER** with fifty (50) or more **EMPLOYEE**S, at the address shown and can be inspected by **EMPLOYEE**S at any time during normal business hours. In addition this document is the Plan Document and the Summary Plan Description.

Plan Administrator For the purposes of this **PLAN** shall be City of Burlington.

Plan Sponsor For the purposes of this **PLAN** shall be "**PLAN SPONSOR**" as defined by any applicable law within the State of Vermont and/or Federal Laws and further defined in the definition section of the Plan Document/Summary Plan Description.

Plan Supervisor For the purposes of this **PLAN** shall mean GROUP INSURANCE SERVICE CENTER, INC.

Plan Year For the purposes of this **PLAN** shall mean a period of time commencing on January 1st and ending on December 31st.

Post Service Claim For the purposes of this **PLAN** are all claims not considered **PRE-SERVICE CLAIMS**.

PPACA For the purposes of this **PLAN** shall mean the Patient Protection and Affordable Care Act as amended from time to time.

Pre-admission Certification

For the purposes of this **PLAN** shall mean the procedure to approve a hospitalization prior to admission. Refer to **HOSPITAL** PRE-ADMISSION CERTIFICATION BENEFIT SECTION.

Pre-admission Testing

For the purposes of this **PLAN** shall mean necessary lab and X-rays performed prior to **HOSPITAL** admission. Refer to SCHEDULE OF BENEFITS.

Preferred Provider

For the purposes of this **PLAN** shall mean Networks utilized by the **PLAN** and listed in the *HOW TO FILE A CLAIM* section of this document. The Network is also listed on the **COVERED PERSON'S** ID Card.

Pre-Service Claims

For the purposes of this **PLAN** is any request for approval of a benefit which the terms of the **PLAN** condition receipt of the benefit in whole or in part, on approval of the benefit in advance of obtaining treatment. (Example: Pre-Certification of a **HOSPITAL** admission and prior authorization is a **PRE-SERVICE CLAIM**.)

Preventive Services

For the purposes of this **PLAN** shall mean that this Plan intends to comply with the Affordable Care Act's (ACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with the ACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

Psychologist

For the purposes of this **PLAN** shall mean an individual holding the degree of Ph.D. in Clinical Psychology and acting within the scope of his license.

Qualified Medical Child Support Order (QMCSO)

For the purposes of this **PLAN** shall mean a judgment, decree or order, issued by a court of competent jurisdiction creating a right for the named **CHILD** of a **COVERED EMPLOYEE** to become eligible under the **PLAN**. This order must meet all of the requirements specified in **OBRA 93** as it may be amended from time to time.

Qualifying Part time Employee for the Purposes of 4980H Eligibility

For the purposes of this **PLAN** and the employer mandate, employees are considered to be full-time employees if they are employed an average of at least 20 hours of service per week with the employer. Employers may consider employees employed an average of less than 20 hours of service per week to be part time (20 hours is the maximum requirement to be full time). The designation of "full-time" or "part-time" status for purposes of the employer mandate/the health plan may differ from the employer's designation of "full-time" and "part-time" status for other purposes.

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

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

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

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

Reconstructive Surgical Procedure For the purposes of this **PLAN** shall mean a surgical procedure which corrects and/or restores an abnormality from birth; or an abnormality sustained from **INJURY** or **ILLNESS**.

Registered Nurse For the purposes of this **PLAN** shall mean an individual who has received specialized nursing training, is authorized to use the designation of R.N., and who is duly licensed by the regulatory agency responsible for such licensing in the political jurisdiction in which the individual performs such nursing services. Shall also include graduate nurse (G.N.).

Regular Full-Time Employees For the purposes of this **PLAN** shall mean Employees designated by the Employer as Regular Full-time Employees. With respect to a calendar month, an Employee who is employed an average of at least 20 hours of service per week with the Employer.

Rehabilitative Services For the purposes of this **PLAN** shall mean a health service that allows a **COVERED PERSON** to reacquire a functional skill that was previously present but has been lost due to **ILLNESS** or **INJURY** (for example: speech therapy for an adult who has suffered a stroke).

Retirees For the purposes of this **PLAN** refer to SUMMARY PLAN INFORMATION SECTION.

Return to Active Service For the purposes of this **PLAN** shall mean the day, which is a scheduled work day, the **ELIGIBLE EMPLOYEE** has resumed all of the normal activities of a person of the same age and has resumed all of the regular duties of his employment, either at his customary place of employment, or at some location to which that employment requires him to travel.

Room and Board

For the purposes of this **PLAN** shall mean all charges, by whatever name called, which are made by a **HOSPITAL**, **HOSPICE**, or **EXTENDED CARE FACILITY / SKILLED NURSING FACILITY / REHABILITATION FACILITY** as a condition of occupancy. Such charges do not include the professional services of **PHYSICIAN**S nor private duty nursing care, by whatever name called.

Routine Care For the purposes of this **PLAN** shall mean medical treatment, services or supplies rendered to a **COVERED PERSON** solely for health maintenance or prevention, and not for the treatment of an **ILLNESS** or **INJURY**, except for maternity expenses which may be considered the same as any **ILLNESS**.

Scheduled Benefit Amount For the purposes of this **PLAN** means a specified dollar amount that will be considered for reimbursement under the **PLAN** for a particular type of medical care, service or supply provided. **SCHEDULED BENEFITS** are based upon covered expenses not otherwise limited or excluded under the terms of the **PLAN**. A partial listing of scheduled benefit amounts may be found in the section, "Schedule of Benefits".

SCHEDULED BENEFIT AMOUNTS are determined taking into consideration (but not restricted to) the lesser of the **USUAL AND CUSTOMARY** fee for services and/or supplies, which are deemed to be both **REASONABLE** and **MEDICALLY NECESSARY.**

Semi-Private For the purposes of this **PLAN** shall mean a class of accommodation in a **HOSPITAL** or convalescent nursing facility in which at least two (2) patient beds are available per room.

Skilled Nursing Care For the purposes of this **PLAN** shall mean medical services rendered by order of a **PHYSICIAN** by a **REGISTERED NURSE** or **LICENSED PRACTICAL NURSE**.

Social Worker For the purposes of this **PLAN** shall mean a person who has a masters degree in social work, is licensed in the political jurisdiction where practicing, and is acting within the scope of that license.

Special Care Units Of Hospitals For the purposes of this **PLAN** shall mean an additional service rendered by a separate **HOSPITAL** department which includes but is not limited to:

- Burn Care
- Cardiac Care
- Intensive Care
- Pediatric Intensive Care; and

1. Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; and
2. Has special supplies and equipment, necessary for such care and treatment, available on a stand-by basis for immediate use; and
3. Provides **ROOM AND BOARD** and constant observation and care by **REGISTERED NURSE**S or other specially trained **HOSPITAL** personnel; excluding any **HOSPITAL** facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Special Enrollment Event For the purposes of this **PLAN** is when an **ELIGIBLE EMPLOYEE** (1) who previously declined coverage under this **PLAN** at his initial enrollment because he had other coverage loses his other source of group or individual coverage, or (2) loses coverage because of a certain event, such as the loss of eligibility for coverage, expiration of COBRA continuation coverage, termination of employment, reduction in number of hours, or (3) **EMPLOYER** contributions towards such coverage were terminated, or (4) **ELIGIBLE EMPLOYEE** who acquires a new **DEPENDENT** through marriage, birth or adoption and (5) **ELIGIBLE EMPLOYEE** acquires a new **DEPENDENT** who is a **CHILD** that has been placed for adoption, regardless of whether this **ELIGIBLE EMPLOYEE** is also a **COVERED EMPLOYEE**. (6) Also, an **ELIGIBLE EMPLOYEE** or **ELIGIBLE DEPENDENT** who loses eligibility and/or state premium assistance for Medicaid or Children's Health Insurance Coverage (CHIP) regardless of whether the **EMPLOYEE** is also a **COVERED EMPLOYEE**. These events enable the **ELIGIBLE EMPLOYEE** and any **ELIGIBLE DEPENDENT** to enroll for coverage during the **SPECIAL ENROLLMENT PERIOD**. *Voluntary termination of other coverage does not in itself create a **SPECIAL ENROLLMENT EVENT*** under **SPECIAL ENROLLMENT**. All other requirements of **SPECIAL ENROLLMENT** stated in **HIPAA** and its amendments will be adhered to.

Special Enrollment Period For the purposes of this **PLAN** is the thirty (30) day period immediately following a **SPECIAL ENROLLMENT EVENT** during which the **ELIGIBLE EMPLOYEE** may enroll in the **PLAN**. If the **SPECIAL ENROLLMENT EVENT** is loss of eligibility and/or state premium assistance the 30 day enrollment period is extended to 60 days. Coverage will be effective the date of the **SPECIAL ENROLLMENT EVENT**. Failure to enroll during this period will result in a denial of coverage.

Stability Period for 4980H Eligiblity For the purposes of this **PLAN** shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is January 1st through December 31st in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Standard Measurement Period for 4980H Eligiblity For the purposes of this **PLAN** for Ongoing Employees, this Measurement Period will start on January 1st each year and will last for 12 consecutive months.

Statement of Domestic Partnership For the purposes of this **PLAN** shall mean a standard form used to apply for coverage of a Domestic Partner.

Subrogation For the purposes of this **PLAN** shall mean a right or recovery against any person, insurance company, or other entity, first or third party, that is in any way responsible for providing compensation or other payment as a result of any **INJURY** or **ILLNESS** or other loss. Refer to Subrogation section of this **PLAN** for details.

Termination of Domestic Partnership For the purpose of this **PLAN** shall mean a standard form to terminate a Domestic Partnership.

Urgent Care Claims For the purposes of this **PLAN** is any **CLAIM** for medical care or treatment which in the judgment of a prudent lay person possessing an average knowledge of health and medicine:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. in the opinion of a **PHYSICIAN** with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed with out the care or treatment that is the subject of the **CLAIM**.

USERRA For the purposes of this **PLAN** shall mean the Uniformed Services Employment and Reemployment Rights Act as amended from time to time.

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

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

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

The term "**USUAL AND CUSTOMARY**" does not necessarily mean the actual charge made nor the specific service or supply furnished to a **PLAN COVERED PERSON** by a Provider of services or supplies, such as a **PHYSICIAN**, therapist, nurse, hospital, or pharmacist. The **PLAN ADMINISTRATOR** will determine what the **USUAL AND CUSTOMARY** charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is **USUAL AND CUSTOMARY**.

USUAL AND CUSTOMARY charges may, at the **PLAN ADMINISTRATOR**'s discretion, alternatively be determined and established by the **PLAN** using normative data such as, but not limited to, PPO arrangements, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Variable Hour Employee for 4980H Eligibility For the purposes of this **PLAN** shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

Waiting Period For the purposes of this **PLAN** shall mean the period of time, dating from the first day of employment, after which an **EMPLOYEE** will become eligible for coverage under this **PLAN**.

- **Health Claims**

The **PLAN ADMINISTRATOR** shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the **PLAN** will be paid only if the **PLAN ADMINISTRATOR** decides in its discretion that the **COVERED PERSON** is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the **PLAN SUPERVISOR**; provided, however, that the **PLAN SUPERVISOR** is not a fiduciary of the **PLAN** and does not have the authority to make decisions involving the use of discretion.

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

A call from a **PROVIDER** who wants to know if an individual is covered under the **PLAN**, or if a certain procedure is covered by the **PLAN**, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the **PLAN**. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all **PLAN** provisions, limitations and exclusions.

- **Notice and Proof of Claim**

Written notice of **INJURY** or **ILLNESS** upon which claim may be based must be given to the **PLAN ADMINISTRATOR**, or its designee within one year of the date expenses are incurred for which benefits arising out of such **INJURY** or **ILLNESS** may be claimed. Claims submitted after one (1) year will be denied.

Notice given by or on behalf of the **COVERED PERSON** to the **PLAN ADMINISTRATOR** with particulars sufficient to identify the **COVERED PERSON** shall be deemed to be notice to the **PLAN ADMINISTRATOR**. The **PLAN ADMINISTRATOR**, upon receipt of the notice required by this **PLAN**, will furnish to the **COVERED PERSON** such forms for filing proof of loss.

Proof of loss must be furnished to the **PLAN ADMINISTRATOR** within one (1) year after the termination of the period for which claim is made or one (1) year after expenses are incurred, whichever comes first. Failure to furnish proof within the time provided in this **PLAN** shall not invalidate or reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof.

Each **COVERED PERSON** shall file with the **PLAN ADMINISTRATOR** or the **PLAN SUPERVISOR** such information as is necessary to determine eligibility or proof of dependency. It is the **COVERED PERSON**'S responsibility to provide this information or benefits under this **PLAN** may be withheld until requested information is received. Refer to HOW TO FILE A CLAIM SECTION.

- **Claim Procedures**

CLAIMS received will be considered in accordance with **PLAN** benefits and based on **CLAIM** type as indicated below:

1. **URGENT CARE CLAIMS** will have benefit determination made within seventy-two (72) hours of receipt by the **PLAN** or its designee. Notice of insufficient information that would enable the **PLAN** to make its benefit determination will be sent to the **COVERED PERSON** within twenty-four (24) hours of initial receipt of the **URGENT CARE CLAIM**.

2. **PRE-SERVICE CLAIMS** will have benefit determination made within fifteen (15) calendar days of receipt by the **PLAN** or its designee. This fifteen (15) day period may be extended another fifteen (15) days allowing for additional information to be obtained provided that the additional information required is beyond the **PLAN'S** control to provide but, final benefit determination must be made no later than thirty (30) days after initial receipt. Notice of insufficient information that would enable the **PLAN** to make its benefit determination will be sent to the **COVERED PERSON** within five (5) calendar days of initial receipt of the **PRE-SERVICE CLAIM**. Notice to a **COVERED PERSON** of an extension of time will be provided within the initial 15-day period, and such notice will include (i) a description of the circumstances requiring the extension, and (ii) the date by which the **PLAN** expects to make its decision, and (iii) in the case of needing more information, a description of the required information. Also, upon receipt of a notice of insufficient information, the **COVERED PERSON** has forty-five (45) days to provide the requested information and general claims time limitations are tolled during this period.

3. **POST SERVICE CLAIMS** will have benefit determination made within thirty (30) calendar days of receipt by the **PLAN** or its designee. This 30-day period may be extended one time by the **PLAN** for up to fifteen (15) days, provided that the **PLAN ADMINISTRATOR** both determines that such an extension is necessary due to matters beyond the control of the PLAN and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the PLAN expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

4. **URGENT CARE** and **PRE-APPROVAL CLAIMS** only meet with the criteria stated above if the **PLAN** requires prior authorization for the benefit in question.

   A concurrent care decision which is any decision by the **PLAN** to terminate or reduce benefits that have already been granted and have the potential to cause disruption to ongoing care, course of treatment, number of treatments or, treatments provided as **MEDICALLY NECESSARY** are subject to **URGENT CARE CLAIMS** guidelines. Further any **URGENT CARE CLAIM** requesting to extend a course of treatment beyond the initially described treatment must be decided within twenty-four (24) hours provided that the **CLAIM** is made at least twenty-four (24) hours prior to the expiry of the initially prescribed treatment.

   It is the responsibility of the **COVERED PERSON** to ensure that any information requested by the **PLAN** or its designee to determine benefits be provided.

   The **COVERED PERSON** can volunteer to an extension of the above stated time frames, which will add an additional level of appeal.

Similarly situated **CLAIMS** are, under similar circumstances, decided in a consistent manner. This consistency might be ensured by utilizing protocols, guidelines, medical criteria, rate tables, fee schedules, etc. The **PLAN ADMINISTRATOR** may further ensure and verify this consistent decision making by periodic exams, reviews or audits of **CLAIMS**.

Should the **PLAN ADMINISTRATOR** deny, in whole or in part, the payment of consideration of any **CLAIM**, the **PLAN ADMINISTRATOR** shall provide the **COVERED PERSON** a written explanation indicating the specific reason for the denial or adverse benefit determination. This explanation which may be provided on the explanation of benefits or in standard letter format will include the reason for denial with specific references to the pertinent **PLAN** provisions on which denial is based, a description of any additional material or information necessary for the **CLAIM** to be approved and an explanation of why such material or information is necessary. Refer to the Claim Review/Appeal Procedure for the procedures and timelines relative to obtaining additional review.

- **Examination**

The **PLAN ADMINISTRATOR** shall have the right and opportunity to examine the person of any individual whose **INJURY** or **ILLNESS** is the basis of a claim hereunder and when and so often as it may reasonably require during pendency of the claim. The **PLAN ADMINISTRATOR** shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law. The **PLAN ADMINISTRATOR** has the right to have a **PHYSICIAN** of its choice perform these services.

- **CLEAN CLAIM**

For the purposes of this **PLAN** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A **CLEAN CLAIM** does not include claims under investigation for fraud and abuse or claims under review for **MEDICAL NECESSITY** and **REASONABLENESS**, or fees under review for **USUAL AND CUSTOMARINESS**, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a **CLEAN CLAIM**. A Provider submits a **CLEAN CLAIM** by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The **PLAN ADMINISTRATOR** may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a **CLEAN CLAIM** if the **COVERED PERSON** has failed to submit required forms or additional information to the **PLAN** as well.

- **Payment Of Claims**

All **PLAN** benefits are payable to the **COVERED PROVIDER** or subject to any written direction of the **COVERED PERSON** as long as the written direction is allowed in accordance with the Assignment Section in the **PLAN.** If any such benefits remain unpaid at the death of the **COVERED PERSON** or if the **COVERED PERSON** is a minor or is legally incapable of giving a valid receipt and discharge for any payment the **PLAN ADMINISTRATOR** may at its option pay such benefits to the **COVERED PERSON** or **COVERED PROVIDER** with whom the **COVERED EXPENSES** were incurred if the expenses have not otherwise been paid. Any payment so made will constitute a complete discharge of this **PLAN'S** obligation to the extent of such payment.

- **Claim Review/ Appeal Procedure**

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;
d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

- **Rights Of Recovery**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the **PLAN**'s terms, conditions, limitations or exclusions, or should otherwise not have been paid by the **PLAN**. As such this **PLAN** may pay benefits that are later found to be greater than the **MAXIMUM ALLOWABLE CHARGE**. In this case, this **PLAN** may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the **PLAN** pays benefits exceeding the amount of benefits payable under the terms of the **PLAN**, the **PLAN ADMINISTRATOR** has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the **COVERED PERSON** or dependent on whose behalf such payment was made.

A **COVERED PERSON**, **DEPENDENT**, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the **PLAN** or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the **PLAN** within 30 days of discovery or demand. The **PLAN ADMINISTRATOR** shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The **PLAN ADMINISTRATOR** shall have the sole discretion to choose who will repay the **PLAN** for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a **COVERED PERSON** or other entity does not comply with the provisions of this section, the **PLAN ADMINISTRATOR** shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the **COVERED PERSON** and to deny or reduce future benefits payable (including payment of future benefits for other injuries or **ILLNESS**) under the **PLAN** by the amount due as reimbursement to the **PLAN**. The **PLAN ADMINISTRATOR** may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or **ILLNESSES**) under any other group benefits plan maintained by the **PLAN SPONSOR**. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the **PLAN** or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this **PLAN** and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the **PLAN ADMINISTRATOR** or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the **PLAN** within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the **PLAN** must bring an action against a **COVERED PERSON**, **PROVIDER** or other person or entity to enforce the provisions of this section, then that **COVERED PERSON**, **PROVIDER** or other person or entity agrees to pay the **PLAN**'s attorneys' fees and costs, regardless of the action's outcome.

Further, **COVERED PERSON**s and/or their **DEPENDENTS**, beneficiaries, estate, heirs, guardian, personal representative, or assigns (**COVERED PERSON**s) shall assign or be deemed to have assigned to the **PLAN** their right to recover said payments made by the **PLAN**, from any other party and/or recovery for which the **COVERED PERSON**(s) are entitled, for or in relation to facility-acquired condition(s), **PROVIDER** error(s), or damages arising from another party's act or omission for which the **PLAN** has not already been refunded.

The **PLAN** reserves the right to deduct from any benefits properly payable under this **PLAN** the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this **PLAN** within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a **COVERED PERSON** fails to comply with the **PLAN**'s Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational **INJURY** or **ILLNESS** to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the **PLAN** to pay benefits under this **PLAN** in any such instance.

The deduction may be made against any claim for benefits under this **PLAN** by a **COVERED PERSON** or by any of his Covered Dependents if such payment is made with respect to the **COVERED PERSON** or any person covered or asserting coverage as a Dependent of the **COVERED PERSON**.

If the **PLAN** seeks to recoup funds from a **PROVIDER**, due to a claim being made in error, a claim being fraudulent on the part of the **PROVIDER**, and/or the claim that is the result of the **PROVIDER**'s misstatement, said **PROVIDER** shall, as part of its assignment to benefits from the **PLAN**, abstain from billing the plan **COVERED PERSON** for any outstanding amount(s).

- **Agent For Service Of Legal Process**

The agent for the service of legal process under this **PLAN** shall be the **PLAN ADMINISTRATOR** shown in the Introduction and General Plan Information pages.

- **Time Limitation**

If any time limitation of this **PLAN** with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted under the guidelines of State of Vermont and/or any federal law, such limitation is hereby extended to agree with the minimum period permitted by such law.

- **Worker's Compensation Not Affected**

This **PLAN** is not in lieu of, and does not affect any requirement for, coverage by Worker's Compensation Insurance.

- **Plan Amendment**

The **EMPLOYER** may amend this **PLAN** at any time and will provide written notice to **COVERED EMPLOYEES.** Notice of **PLAN** reductions or modifications will be made to **COVERED PERSONS** within sixty (60) days of the changes. **PLAN AMENDMENTS** can be made retroactive to the extent permitted by law. If any provision of this **PLAN** is contrary to any law to which it is subject, such provision will be automatically amended to conform to the applicable law.

- **Assignment**

Benefits for medical expenses covered under this **PLAN** may be assigned by a **COVERED PERSON** to the **PROVIDER** as consideration in full for services rendered; however, if those benefits are paid directly to the **EMPLOYEE**, the **PLAN** shall be deemed to have fulfilled its obligations with respect to such benefits. The **PLAN** will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered **EMPLOYEE** and the assignee, has been received before the proof of loss is submitted.

No **COVERED PERSON** shall at any time, either during the time in which he or she is a **COVERED PERSON** in the **PLAN**, or following his or her termination as a **COVERED PERSON**, in any manner, have any right to assign his or her right to sue to recover benefits under the **PLAN**, to enforce rights due under the **PLAN** or to any other causes of action which he or she may have against the **PLAN** or its fiduciaries.

A **PROVIDER** which accepts an assignment of benefits, in accordance with this **PLAN** as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

- **Plan Termination**

The **EMPLOYER** may terminate this **PLAN**. Upon termination the rights of **COVERED PERSONS** to benefits are limited to claims incurred prior to the date of termination and eligible up to the date of termination. Any termination of this **PLAN** will be communicated to the **EMPLOYEES** by the **PLAN ADMINISTRATOR**. The allocation and deposition of **PLAN** assets will be managed and notice provided as required by all applicable law.

- **Miscellaneous**

If appropriate in accordance with **HIPAA**, this **PLAN** may be disclosed to **COVERED PERSONS** through electronic media.

HIPAA Non-discrimination Rules will be effective under the **PLAN**. These include, but are not limited to;

1. Non-discrimination for eligibility based on "health factor" defined by the Rules.
2. Prohibits discrimination in contributions or premiums in the same class/division.
3. Non-discrimination preventing group health plans from adjusting contribution amounts or premiums on the basis of genetic information as defined in the Genetic Information and Non-discrimination Act of 2008 (Public Law No. 110-233).

The **PLAN** may disclose Protected Health Information as defined in **HIPAA** when necessary, but will protect the privacy rights of the **COVERED PERSON** while doing.

Payment for expenses in relation to services which are generally accepted as cost-containment measures including, but not limited to case management and audit fees, that may not normally be covered under this **PLAN** shall be reimbursable upon recommendation of the **PLAN ADMINISTRATOR** and/or written approval by the **PLAN ADMINISTRATOR**.

- **Newborn and Mothers' Health Protection Act**

  Statement of Rights Under the Newborns' and Mothers' Health Protection Act §603: Under Federal law, group health plans offering group health 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 48 hours following a vaginal delivery, or less than 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., your 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 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. The 48 or 96 hour time frame begins at the time of delivery. 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 of up to 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 pre-certification. For information on pre-certification, contact your **PLAN ADMINISTRATOR**.

- **Medicare, Medicaid and SCHIP Extension Act**

  Registration and Reporting Requirements outlined in the Medicare, Medicaid and SCHIP Extension Act of 2007 will be adhered to.

- **Women's Health and Cancer Rights Act**

  The **PLAN** will conform to all of the requirements of the Women's Health and Cancer Rights Act (WHCRA) (P.L. 105-277). This includes, but may not be limited to the provision of:
  - mastectomies and related services
  - reconstruction of the breast on which the mastectomy has been performed
  - surgery and reconstruction on the other breast to produce a symmetrical appearance
  - treatment of physical complications at all stages of mastectomy including lymphademas
  - medically necessary prosthesis.

  Coverage provided by the **PLAN** for services under the WHCRA will be provided at the same level as all other medical surgical benefits in the **PLAN** and in accordance with the treatment plan determined by the **PHYSICIAN** and **COVERED PERSON.** Contact the **PLAN ADMINISTRATOR** or **PLAN SUPERVISOR** indicated on page 6 with any questions.

- **Verification of Benefits**

  Any verification of benefits given to a **COVERED PERSON** or other party orally, in person, or by telephone is not a guarantee of payment under the **PLAN**. Claims incurred based upon oral advice may not be payable and, if upon receipt and investigation is determined to be not payable under the **PLAN**, will become the responsibility of the **COVERED PERSON**.

- **National Correct Coding Initiative**

  Where not otherwise specified, this **PLAN** follows National Correct Coding Initiative for coding, modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The **PLAN ADMINISTRATOR** has full discretionary authority to select guidelines and/or vendors to assist in determinations.

Section titles are for convenience of reference only and are not to be considered in interpreting this **PLAN**.

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

- **No Loss No Gain Provision**

Upon the **EFFECTIVE DATE** of this **PLAN**, all **EMPLOYEE**S covered under the previous benefit program provided by the **EMPLOYER** shall be eligible for coverage under this **PLAN**.

For any **EMPLOYEE** or **DEPENDENT** whose coverage under the previous benefit program of the **EMPLOYER** is eligible for continuation under that program and whose coverage under this **PLAN** is effective, benefits under this **PLAN** will apply only to those expenses not eligible for payment under continuation of the previous benefit program.

Notwithstanding anything to the contrary, credit under this **PLAN** may be allowed for any portion of a **CALENDAR YEAR DEDUCTIBLE** satisfied under any previous benefit program provided by the **EMPLOYER**.

- **Applicable Law**

This **PLAN** has been established and operates under the guidelines of the State of Vermont and Federal Laws. There is a requirement that certain disclosures must be made to **PLAN COVERED PERSONS**. The following pages provide this information.

- **Clerical Error/Delay**

Clerical errors made on the records of the **PLAN** and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this **PLAN** regardless of whether any contributions with respect to **COVERED PERSON's** have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

- **Conformity with Applicable Laws**

This **PLAN** shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this **PLAN**, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the **PLAN ADMINISTRATOR** to pay claims which are otherwise limited or excluded under this **PLAN**, such payments will be considered as being in accordance with the terms of this **PLAN** Document. It is intended that the **PLAN** will conform to the requirements of the State of Vermont and Federal Laws as it applies to the **PLAN**.

- **Fraud**

  The following actions by any **COVERED PERSON**, or a **COVERED PERSON**'s knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this **PLAN** for the entire Family Unit of which the **COVERED PERSON** is a member:

  1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a **COVERED PERSON** of the **PLAN**;
  2. Attempting to file a claim for a **COVERED PERSON** for services which were not rendered or Drugs or other items which were not provided;
  3. Providing false or misleading information in connection with enrollment in the **PLAN**; or
  4. Providing any false or misleading information to the **PLAN**.

- **Headings**

  The headings used in this **PLAN** Document are used for convenience of reference only. **COVERED PERSON**s are advised not to rely on any provision because of the heading.

- **No Waiver or Estoppel**

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

- **Plan Contributions**

  The **PLAN ADMINISTRATOR** shall, from time to time, evaluate the funding method of the **PLAN** and determine the amount to be contributed by the Participating **EMPLOYER** and the amount to be contributed (if any) by each **COVERED PERSON**.

  The **EMPLOYER** shall fund the **PLAN** in a manner consistent with the provisions of the Internal Revenue Code, and such other laws and regulations as shall be applicable to the end that the **PLAN** shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the **PLAN ADMINISTRATOR** shall be free to determine the manner and means of funding the **PLAN**. The amount of the **COVERED PERSON**'s contribution (if any) will be determined from time to time by the **PLAN ADMINISTRATOR**.

- **Right to Receive and Release Information**

  For the purpose of determining the applicability of and implementing the terms of these benefits, the **PLAN ADMINISTRATOR** may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or **COVERED PERSON** for benefits from this **PLAN**. In so acting, the **PLAN ADMINISTRATOR** shall be free from any liability that may arise with regard to such action. Any **COVERED PERSON** claiming benefits under this **PLAN** shall furnish to the **PLAN ADMINISTRATOR** such information as may be necessary to implement this provision.

- **Written Notice**

  Any written notice required under this **PLAN** which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this **PLAN** shall be interpreted to conform to the minimum requirements of such law.

Case Management Benefit/
GISC TotalCare

- **Case Management Benefit**

  Case management is a program which manages care and permits the provision of alternative medical care not otherwise available under this **PLAN**, that are cost effective and medically beneficial to the **COVERED PERSON** for certain **ILLNESSES** or **INJURIES** which require long term care. This provision of alternative medical care may be in lieu of inpatient hospitalization, based on the consent of the **PLAN ADMINISTRATOR**, or its designee, and the **COVERED PERSON** and must have written confirmation of the medical necessity from the attending **PHYSICIAN**.

  The **PLAN ADMINISTRATOR**, or its designee, will contact a case manager or medical reviewer upon notification that a **COVERED PERSON'S** needs may meet the criteria for medical case management. Other factors which may determine case management participation are length of stay, type of treatment, place of treatment and age of the **COVERED PERSON**.

  Participation in this benefit is voluntary, however, by accepting participation in the **PLAN** all **COVERED PERSONS** agree and consent to the disclosure of your medical records for purposes of the case management program. If you know of a **COVERED PERSON** who may meet the criteria and may be interested in medical case management, please contact the **PLAN SUPERVISOR** at 800-242-4472.

- **GISC/TotalCare**

  Inpatient pre-certification and continued stay review are managed by Cigna

  The 24-Hour physician access is managed by CallMD.

  Mom's Program provides a nurse care manager to work with an expecting mother and is managed by MedWatch.

  Chronic Disease Management assigns a nurse health coach to work with the **COVERED PERSON** and assist with compliance. This is managed by AHDI.

  On-Line Wellness Access is managed by AHDI.

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with City of Burlington provided by City of Burlington to its Employees, its Employee's Dependents and, as applicable, retired Employees. This Notice describes how City of Burlington, may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. This Notice is effective January 1, 2015.

The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling 802-865-7150.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose genetic information for underwriting purposes;
7. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
8. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
9. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
10. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
11. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
12. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
13. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
14. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
15. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
16. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or Third Party Administrator, Group Insurance Service Center, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;

   b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
   c. Locate and notify persons of recalls of products they may be using; and
   d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Participants: The Plan is required to disclose to a Participant most of the PHI in a Designated Record Set when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Participant; and

2. Disclosures to the Secretary of the U.S. Dept of Health and Human Services: The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Participants Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Participant's Rights
The Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Participant would like to be contacted. The Plan will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;
4. Accounting of Disclosures: The Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial;
6. Amendment: The Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Participant has the right to opt out of fundraising contacts.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Privacy Compliance Coordinator Contact Information:

City of Burlington
200 Church Street, Suite B
Burlington, VT 05401
Phone: 802-865-7150
Fax: 802-864-1777
Email/Website: sleonard@burlingtonvt.gov

Additional Contact Information for HIPAA Questions:

City of Burlington
200 Church Street, Suite B
Burlington, VT 05401
Phone: 802-865-7150
Fax: 802-864-1777
Email/Website: sleonard@burlingtonvt.gov

The City of Burlington Employee Group Health Plan (hereinafter "**PLAN**") complies with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 and 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing **PLAN SPONSOR'S** obligations with respect to the security of Electronic Protected Health Information.

I. Definitions

A. **Electronic Protected Health Information** has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
B. **Security Incidents** has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

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

A. **PLAN SPONSOR** shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the **PLAN SPONSOR** creates, receives, maintains or transmits on behalf of the **PLAN**;
B. **PLAN SPONSOR** shall ensure that the adequate separation is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
C. **PLAN SPONSOR** shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
D. **PLAN SPONSOR** shall report to the **PLAN** any Security Incidents of which it becomes aware as described below:

    1. **PLAN SPONSOR** shall report to the **PLAN** within a reasonable time after the **PLAN SPONSOR** becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the **PLAN'S** Electronic Protected Health Information; and
    2. **PLAN SPONSOR** shall report to the **PLAN** any other Security Incident on an aggregate basis every quarter or more frequently upon the **PLAN'S** request.

III. Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

A. Notify the Participant whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    1. Written notice by first-class mail to Participant (or next of kin) at last known address or, if specified by Participant, e-mail;
    2. If Plan has insufficient or out-of-date contact information for the Participant, the Participant must be notified by a "substitute form";

3. If an urgent notice is required, Plan may contact the Participant by telephone.
    i. The breach notification will have the following content:
        1. Brief description of what happened, including date of breach and date discovered;
        2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
        3. Steps Participant should take to protect from potential harm;
        4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

B. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;

C. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and

D. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Participants may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

The following **EMPLOYEES** will be eligible for coverage under the **PLAN** as mandated by **PPACA** and Internal Revenue Code 4980H

INTRODUCTION TO ELIGIBILITY

These policies and procedures supplement certain terms of eligibility set forth in the **PLAN** Summary Plan Description that is effective January 1, 2015. These policies and procedures (the "Procedures") are hereby incorporated into and made a part of the **PLAN**.

DEFINITIONS for IRC 4980H Eligibility (Can be found in the "Definitions" section of this **PLAN**.)

ELIGIBILITY FOR INDIVIDUAL COVERAGE

Each full-time Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month/or coincident with the date of hire, provided the Employee has begun work for his or her Participating Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

Each Variable Hour Employee who has averaged the requisite Hours of Service, as defined herein, will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period, as defined herein.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Impact of Breaks In Service

An Employee who is terminated and rehired will be treated as a New Employee upon rehire, only if the **EMPLOYEE** had a break in coverage of more than thirteen (13) weeks.

Upon return, coverage will be effective immediately, so long as all other eligibility criteria are satisfied.

For an approved Leave of Absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved Leave of Absence, an Employee will be treated as an ongoing Employee, even if the Employee's absence was longer than 13.

The **ELIGIBLE EMPLOYEE** must complete a satisfactory enrollment form within thirty (30) days of the date of eligibility and at that time will be considered a **COVERED PERSON** under this **PLAN**.

If an **ELIGIBLE EMPLOYEE** fails to complete the enrollment form for himself and/or his **ELIGIBLE DEPENDENTS** within the thirty (30) days following completion of the date of eligibility, he will only be able to become covered if he meets the requirements of **SPECIAL ENROLLMENT** or during the **OPEN ENROLLMENT** period. **SPECIAL ENROLLMENT** is available to an otherwise **ELIGIBLE EMPLOYEE** who previously declined coverage under this **PLAN** on account of the availability of other coverage and who loses such other coverage. **ELIGIBLE EMPLOYEES** who acquire new **DEPENDENTS** by marriage, birth or adoption may also enroll for coverage under the **SPECIAL ENROLLMENT** for themselves and their newly acquired **DEPENDENTS**. The **ELIGIBLE EMPLOYEE** must apply for this coverage within thirty (30) days following the date of the event which allows for the **SPECIAL ENROLLMENT**. **ELIGIBLE DEPENDENTS** of this **ELIGIBLE EMPLOYEE** who are not newly acquired may make application for coverage during the **OPEN ENROLLMENT** period.

If an **ELIGIBLE EMPLOYEE** or his **EMPLOYER** receives a **QUALIFIED MEDICAL CHILD SUPPORT ORDER**, the subject of this Order will be added to the **PLAN** in accordance with the requirements outlined in the order. Contact the **EMPLOYER** for more specific information relating to the appropriate procedure.

If coverage classifications are designated in the SCHEDULE OF BENEFITS, any change in the amount or type of coverage available to a **COVERED PERSON** occasioned by a change in the **COVERED EMPLOYEE'S** classification shall become effective automatically on the classification change date.

- **Open Enrollment Period**

  If an **ELIGIBLE EMPLOYEE** and/or **ELIGIBLE DEPENDENT** is currently covered by another employer-sponsored health plan, he may be eligible to be covered under this **PLAN** during the **OPEN ENROLLMENT PERIOD** stated in the SUMMARY PLAN INFORMATION pages. An **ELIGIBLE EMPLOYEE** and his **ELIGIBLE DEPENDENTS**, not previously covered, may also enroll during the **OPEN ENROLLMENT PERIOD** and become a **COVERED EMPLOYEE** and **COVERED DEPENDENT**. A **COVERED EMPLOYEE** may enroll his **ELIGIBLE DEPENDENTS** at this time.

  To enroll a Domestic Partner as a **COVERED DEPENDENT**, the completed **STATEMENT OF DOMESTIC PARTNERSHIP** must accompany the completed enrollment form.

- **Employee Eligibility**

An **EMPLOYEE** shall become a **COVERED PERSON** under this **PLAN** at 12:01 a.m. when the **EMPLOYEE**:

1. Is a **FULL-TIME EMPLOYEE**.

2. Is a **FULL-TIME EMPLOYEE** who has a **SPECIAL ENROLLMENT EVENT**.

3. Was a **FULL-TIME EMPLOYEE** previously in **ACTIVE SERVICE** and who is a **RETIREE** covered under this **PLAN** as of his retirement date.

4. Is a **FULL-TIME EMPLOYEE** who elected coverage under this **PLAN** during **OPEN ENROLLMENT**.

5. and makes the required contribution for coverage.

Notwithstanding the Eligibility Requirements above, coverage will not be effective until first day of the month following completion of the **WAITING PERIOD** as stated in the SUMMARY PLAN INFORMATION SECTION.

With respect to such **COVERED EMPLOYEE** employed by the **EMPLOYER** on the **EFFECTIVE DATE** of this **PLAN**, the date of eligibility shall be the **EFFECTIVE DATE** of this **PLAN**.

An **EMPLOYEE,** who becomes employed by the **EMPLOYER** after the **EFFECTIVE DATE** of this **PLAN**, will become a **COVERED EMPLOYEE** at 12:01 a.m. on the date following:

1. The date of completion of any applicable **WAITING PERIOD** as defined in the SUMMARY PLAN INFORMATION or, if none, upon the date of his eligibility if application is made on or before the date of eligibility. See SUMMARY PLAN INFORMATION SECTION; or

2. The date of completion of any applicable **WAITING PERIOD** or, if none, upon the date of written application if made within thirty (30) days following date of eligibility. See SUMMARY PLAN INFORMATION SECTION; or

- **Dependent Eligibility**

A **COVERED EMPLOYEE'S DEPENDENT** will become eligible for coverage when he meets the definition of an **ELIGIBLE DEPENDENT**, as stated earlier in this **PLAN**. The **ELIGIBLE DEPENDENT** will become a **COVERED DEPENDENT** provided the **COVERED EMPLOYEE** has made the required contribution for **DEPENDENT** coverage, at 12:01 a.m. on the following:

1. The date the **COVERED EMPLOYEE** is eligible for coverage, if on that date he has such **DEPENDENT**;

2. The date the **COVERED EMPLOYEE** gains a **DEPENDENT**, if on that date he is covered by this **PLAN**;

3. The date a **COVERED EMPLOYEE** acquires a newborn **CHILD**, a newly adopted **CHILD**, a **CHILD** who has been placed for adoption, a **CHILD** in probation for adoption, a **CHILD** for which he has legal guardianship (proof will be required), a step-child, or a new spouse, or Domestic Partner and his natural children, adopted children or children for whom the Domestic Partner has assumed legal guardianship, provided such **DEPENDENTS** are enrolled in this **PLAN** within thirty (30) days from the date they are acquired. For **COVERED EMPLOYEES** who previously waived **DEPENDENT** coverage, this immediate enrollment will apply to the newly-acquired **DEPENDENTS** or **DEPENDENTS** who are the subject of **QUALIFIED MEDICAL CHILD SUPPORT ORDER**. All other **DEPENDENTS** of the **COVERED EMPLOYEE**, if **DEPENDENT** coverage was previously declined, will not become eligible to be enrolled in this **PLAN** unless they enroll during the **OPEN ENROLLMENT** period.

4. The date an **ELIGIBLE EMPLOYEE** acquires an **ELIGIBLE DEPENDENT** in accordance with the **SPECIAL ENROLLMENT EVENT** outlined in the definitions section of this **PLAN**.

5. A **CHILD** of a **COVERED EMPLOYEE** covered by this **PLAN** until the end of the month of his 26th birthday and who is incapable of self-sustaining employment by reason of mental retardation or physical disability, principally dependent upon the **COVERED EMPLOYEE** for support and maintenance may apply to extend coverage. Proof of such incapacity and dependency must be furnished to the **PLAN ADMINISTRATOR** by the **COVERED EMPLOYEE** within 30 days of the **CHILD**'s 26th birthday or initial eligibility. The **PLAN ADMINISTRATOR**, or its designee, will approve or deny coverage under this **PLAN** based on satisfactory proof of incapacity and dependency. The **PLAN ADMINISTRATOR** may require, at reasonable intervals during the two years following the **CHILD**'s 26th birthday, subsequent proof of the **CHILD**'s disability and dependency. After such two year period, the **PLAN ADMINISTRATOR** may require subsequent proof not more than once each year. The **PLAN ADMINISTRATOR** has the right to have such **CHILD** examined by a **PHYSICIAN** of the **PLAN ADMINISTRATOR'S** choice to determine the existence of such incapacity.

6. The **COVERED DEPENDENT** continues to be eligible for coverage until the end of the month in which he turns 26.

7. The date the **COVERED EMPLOYEE** is eligible for **RETIREE** coverage, if on that date he has such **DEPENDENT**.

   If any **DEPENDENT** is also a **COVERED EMPLOYEE**, such person shall not be eligible for coverage as both **COVERED EMPLOYEE** and a **COVERED DEPENDENT** for benefit purposes.

   If both parents are eligible to carry their **DEPENDENT** children on their coverages, such **DEPENDENT** children may be covered as **DEPENDENTS** of both parents and eligible for coverage. See **COORDINATION OF BENEFITS** to determine order of benefits.

   If both parents are eligible to carry their **DEPENDENT** children on their coverages and they elect to have coverage under only one parent, such **DEPENDENT** children may be covered as **DEPENDENTS**. In the event that the **EMPLOYEE'S** coverage should terminate, his **COVERED DEPENDENTS** will be eligible to become **COVERED DEPENDENTS** under the remaining parent's **EMPLOYEE COVERAGE**.

- **Special Enrollment for Previously Enrolled COVERED PERSONS**

  DEPENDENTS who had ceased to be eligible to enroll in the **PLAN** prior to the passage of the Patient Protection and Affordable Care Act were provided with a 30 day Special Enrollment opportunity.

  COVERED PERSONS who were previously enrolled, but were terminated from **PLAN** participation because of a prior lifetime limitation provision were provided with a 30 day Special Enrollment opportunity.

- **Employee Effective Date**

  EMPLOYEE coverage under this **PLAN** shall become effective with respect to an **ELIGIBLE EMPLOYEE** at 12:01 a.m. on the day listed on the SUMMARY PLAN INFORMATION SECTION. For an **ELIGIBLE EMPLOYEE** who has a **SPECIAL ENROLLMENT EVENT**, coverage shall become effective at 12:01 a.m. on the day following the **SPECIAL ENROLLMENT EVENT** providing the **ELIGIBLE EMPLOYEE** has made application for coverage under this **PLAN** no later than thirty (30) days following the day of the **SPECIAL ENROLLMENT EVENT**.

- **Dependent Effective Date**

  The **ELIGIBLE DEPENDENT** becomes a **COVERED DEPENDENT** at 12:01 a.m. on the day the **COVERED EMPLOYEE** makes written request for **DEPENDENT** coverage on a form approved by the **PLAN ADMINISTRATOR**, providing they meet at least one of the requirements below:

  1. If the **COVERED EMPLOYEE** makes written request on behalf of the **ELIGIBLE DEPENDENT** on or before the date he becomes eligible for **DEPENDENT** coverage, then he shall become a **COVERED DEPENDENT**.

  2. If the **COVERED EMPLOYEE** makes written request on behalf of his **ELIGIBLE DEPENDENT** within the thirty (30) day period immediately following the first day of eligibility, then he shall become a **COVERED DEPENDENT**.

3. Newborn children of a **COVERED EMPLOYEE** shall be covered from the moment of birth provided **DEPENDENT** coverage is in effect at the time of the newborn's birth and the **COVERED EMPLOYEE** notifies the **PLAN ADMINISTRATOR**. If the **COVERED EMPLOYEE** does not have **DEPENDENT** coverage at the time of the newborn's birth and enrolls the newborn within thirty (30) days of the birth, coverage will be retroactive to the date of birth.

4. If a **DEPENDENT** is acquired other than at the time of his birth, due to a legal guardianship, adoption, probationary adoption, marriage, **QMCSO** (as defined in **OBRA 93**), or decree, or Domestic Partnership, coverage for this new **DEPENDENT** will be effective on the date of such decree, marriage or when placed in the physical custody of the **COVERED EMPLOYEE** if **DEPENDENT** coverage is in effect under this **PLAN** at that time and the **COVERED EMPLOYEE** notifies the **PLAN ADMINISTRATOR** within thirty (30) days. If the **COVERED EMPLOYEE** does not have **DEPENDENT** coverage in effect under this **PLAN** at the time of the decree, or marriage and requests such coverage and properly enrolls this new **DEPENDENT** within the thirty (30) day period immediately following the date of the decree, or marriage, then **DEPENDENT** coverage will become effective on the date of the decree or marriage.

5. If **DEPENDENT** coverage, which was previously declined, is requested under this **PLAN**, the **COVERED EMPLOYEE** may make application for this coverage in accordance with the requirements at **OPEN ENROLLMENT**.

- **Employee Termination**

The **COVERED EMPLOYEE'S** coverage shall terminate at 12:01 a.m. immediately upon the earliest of the following dates, except as provided under CONTINUATION OF COVERAGE SECTION:

1. The day following the end of the month in which the **COVERED EMPLOYEE** terminates employment; or
2. The day on which the **COVERED EMPLOYEE** ceases to be in a class eligible for coverage as stated in the SUMMARY PLAN INFORMATION SECTION; or
3. The day on which the **EMPLOYER** terminates the **COVERED EMPLOYEE'S** coverage; or
4. The day on which this **PLAN** is terminated; or with respect to any **EMPLOYEE** benefits of this **PLAN**, the date of termination of such benefit; or
5. The day following the day the **COVERED EMPLOYEE** dies; or
6. The day the **COVERED EMPLOYEE** enters the military of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any **CALENDAR YEAR**; or
7. The day the **COVERED EMPLOYEE** fails to make any required contribution for coverage; or
8. The day following the end of three (3) months of approved medical leave or FMLA, including any FMLA extensions.
9. The last day of the month following the end of the Stability Period for Variable Hour Employees if the EMPLOYEE failed to qualify during the previous Measurement Period.

- **Dependent Termination**

Unless stated to the contrary in #4 of the SUMMARY PLAN INFORMATION section, the **COVERED DEPENDENT'S** coverage shall terminate at 12:01 a.m. immediately upon the earliest of the following dates, except as provided under CONTINUATION OF COVERAGE SECTION:

1. The day following the end of the month in which the **COVERED DEPENDENT** ceases to be an **ELIGIBLE DEPENDENT** including divorce or legal separation or the end of the month in which he turns 26; or if a **COVERED DEPENDENT** would otherwise lose coverage due to a Qualifying Event, he will remain covered by the **PLAN** until the end of the month during which he has the Qualifying event; or
2. The day the **COVERED EMPLOYEE'S** coverage under this **PLAN** terminates; or
3. The day on which the **COVERED EMPLOYEE** ceases to be in a class eligible for **DEPENDENT** coverage; or
4. The day this **PLAN** is terminated; or with respect to any **COVERED DEPENDENT'S** benefit of this **PLAN**, the date of termination of such benefit; or
5. The day the **EMPLOYER** terminates the **COVERED DEPENDENT'S** coverage; or
6. The day such **COVERED DEPENDENT** enters the military of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any **CALENDAR YEAR**; or
7. The day the **COVERED EMPLOYEE** fails to make any required contribution for **DEPENDENT** coverage.
8. The day of termination of a Domestic Partnership.

Note: Refer to Continuation of Coverage Section to see how you may qualify to remain on the **PLAN** after termination as stated above.

Continuation Of Coverage COBRA

CONTINUATION OF COVERAGE is offered to **COVERED EMPLOYEES** and their **COVERED DEPENDENTS** allowing them the opportunity to continue participation in this **PLAN** (including any **PLAN** modifications occurring during such period of continuation coverage) after their coverage would otherwise cease due to a Qualifying Event. **CONTINUATION OF COVERAGE** will be subject to timely election and receipt of payment of premiums by a Qualified Beneficiary as described throughout the **CONTINUATION OF COVERAGE** section.

The coverage provided under the continuation plan may not be conditional or discriminate on the basis of evidence of insurability and must be identical to the coverage provided to similarly situated **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** for whom a Qualifying Event has not occurred. In general, Qualified Beneficiaries electing to continue coverage are subject to the same **DEDUCTIBLES** and limits as a similarly situated **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** for whom a Qualifying Event has not occurred. Also, the Qualified Beneficiary is subject to the same rules regarding these **DEDUCTIBLES** and limits within the **PLAN** year as to which similarly situated **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** are subject.

If a **PROVIDER** makes an inquiry regarding eligibility or benefits while a Qualified Beneficiary does not yet have coverage, they should be advised of that and that if COBRA coverage is elected timely and premiums paid coverage will be retroactive. The same will apply to **PROVIDER** inquiries made while the Qualified Beneficiary is in any grace period for paying COBRA premiums.

For the purpose of this coverage, the following requirements and limitations shall apply:

- **Qualifying Events**

  A Qualifying Event occurs if a **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** lose coverage as a result of:

  1. The death of a **COVERED EMPLOYEE**;
  2. Termination of the **COVERED EMPLOYEE** (other than by reason of such **COVERED EMPLOYEE'S** gross misconduct); reduction in a **COVERED EMPLOYEE'S** hours of employment; or retirement;
  3. The divorce or legal separation of the **COVERED EMPLOYEE** from the spouse who is a **COVERED DEPENDENT**;
  4. The day on which the **COVERED EMPLOYEE** becomes entitled to **MEDICARE** benefits, whether or not he remains covered under this **PLAN**. The **COVERED DEPENDENTS** of the **COVERED EMPLOYEE** are then entitled to continue health coverage from the date of **MEDICARE** entitlement;
  5. A **COVERED DEPENDENT CHILD** ceasing to be an eligible **DEPENDENT**;
  6. The day a **COVERED EMPLOYEE** on **FMLA** leave exhausts the 12 week leave period including any other approved extension, without returning to work or makes it known he will not be returning to employment, whichever occurs first.
  7. Bankruptcy, see Bankruptcy Section. Note: Use this only if **PLAN** covers **RETIREES**.

- **Persons Eligible For Continuation Of Coverage**

Qualified Beneficiary

A Qualified Beneficiary is any **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** who lose coverage as a result of a Qualifying Event. The Qualified Beneficiaries eligible for **CONTINUATION OF COVERAGE** under the **EMPLOYER**'S group health plan are:

1. widowed spouses and **DEPENDENT** children;
2. **COVERED EMPLOYEES** (and their spouses and **DEPENDENT** children) who have been terminated for reasons other than **COVERED EMPLOYEE'S** gross misconduct, or have had their hours reduced (resulting in a loss of coverage);
3. divorced or legally separated spouses and their **DEPENDENT** children;
4. **MEDICARE** ineligible spouses and their **DEPENDENT** children (**COVERED EMPLOYEE** becomes entitled to **MEDICARE** leaving his spouse and their **COVERED DEPENDENT** children without medical coverage);
5. **COVERED DEPENDENT** children no longer meeting this **PLAN'S** definition of a **COVERED DEPENDENT CHILD**.
6. A **CHILD** born to or placed for adoption with a **COVERED EMPLOYEE** during the period of **COBRA** coverage.

Non-Resident Alien Exception

The term Qualified Beneficiary does not include an individual whose status as a **COVERED EMPLOYEE** is attributable to a period in which such individual was a non-resident alien who received no earned income (within the meaning of section 911(d)(2) of the Internal Revenue Code) from the **EMPLOYER** which constituted income from sources within the United States (within the meaning of Section 861 (a3). If an individual is not a Qualified Beneficiary pursuant to the previous sentence, a spouse or **DEPENDENT CHILD** of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

- **Notification**

The **EMPLOYER** shall notify the **PLAN ADMINISTRATOR**, or its designee, within thirty (30) days of the occurrence of a Qualifying Event with respect to the **COVERED EMPLOYEE**.

It is the responsibility of the **COVERED EMPLOYEE** or Qualified Beneficiary to notify the **PLAN ADMINISTRATOR** within sixty (60) days after the date of the Qualifying Event or loss of coverage date, or the date on which the Qualified Beneficiary is informed of the obligation to provide notice and the procedures for providing such notice, if the event involves:

1. Divorce or legal separation of the **COVERED EMPLOYEE** from the **COVERED EMPLOYEE'S** spouse;
2. A **COVERED DEPENDENT CHILD** ceasing to be an **ELIGIBLE DEPENDENT**.

It is the responsibility of the Qualified Beneficiary to notify the **PLAN ADMINISTRATOR** of his disability if he is determined by Social Security to be disabled at the time of termination or a reduction in hours and/or at anytime during the first sixty (60) days of his **COBRA** coverage. Notification must be made within sixty (60) days after the date the Qualified Beneficiary receives a disability determination from social security or the date on which the Qualifying Event occurs or the date on which the Qualifying Beneficiary loses coverage or the date on which the Qualified Beneficiary is informed of the obligation to provide notice and

the procedures for providing such notice and before the end of the eighteen (18) month period of coverage. Also, a disabled Qualified Beneficiary must notify the **PLAN ADMINISTRATOR** within thirty (30) days of the date of any final social security determination that the Qualified Beneficiary is no longer disabled or the date on which the Qualified Beneficiary is informed of the obligation to provide notice and the procedures for providing such notice.

Notice by the **COVERED EMPLOYEE** or Qualified Beneficiary to the **PLAN ADMINISTRATOR** may be given by contacting the Human Resource Department of the **EMPLOYER.**

Failure of the **COVERED EMPLOYEE** or Qualified Beneficiary to notify the **PLAN ADMINISTRATOR** in a timely manner may void rights to CONTINUATION OF COVERAGE. Contact the Human Resource Department to provide proper notice.

- **How Continuation Of Coverage Is To Be Offered**

The **PLAN ADMINISTRATOR**, or its designee, must notify, in writing, the **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** (when they are first covered under this **PLAN**) that he would lose coverage because of a Qualifying Event and that he has the right to elect coverage under **CONTINUATION OF COVERAGE**.

The **PLAN ADMINISTRATOR**, or its designee, has fourteen (14) days to notify a Qualified Beneficiary after the **PLAN ADMINISTRATOR** has been notified of a Qualifying Event. The option of electing coverage must be decided upon by the Qualified Beneficiary within the later of sixty (60) days from the end of coverage or sixty-seven (67) days from the date the notification was sent to the Qualified Beneficiary. The additional seven (7) days allow for mail time. The Qualified Beneficiary then has forty-five (45) days from election date to pay the premium from his Qualifying Event through the election date. If a health care provider inquires about benefits when a Qualified Beneficiary is in the election period and/or the grace period for premium payment, the health care provider will be informed coverage is not currently in force. Further, the health care provider will be told coverage will be retroactively reinstated if COBRA coverage is elected and subsequently paid for.

- **Period Of Coverage**

The coverage must extend for at least the period beginning on the date of the Qualifying Event and ending not later than the earliest of the following:

1. A terminated **EMPLOYEE**, but not an **EMPLOYEE** whose coverage was terminated for reasons other than gross misconduct, or one whose reduction of hours has caused loss of medical coverage - 18 months for the **EMPLOYEE** and **ELIGIBLE DEPENDENTS**. If a Qualified Beneficiary is disabled by the Social Security Administration at the time of this event or within the first sixty (60) days of COBRA coverage, he may extend CONTINUATION OF COVERAGE an additional eleven (11) months (29 months total) provided that the Qualified Beneficiary gives the proper notification. See Notification Section. This does not apply to a **COVERED EMPLOYEE** who was terminated for reasons of gross misconduct.

2. Widowed **DEPENDENT** spouse and **DEPENDENT** children - 36 months.
3. Divorced or legally separated **DEPENDENT** spouse - 36 months.
4. **DEPENDENT** spouse and **DEPENDENT** children of retiring **COVERED EMPLOYEE** entitled to **MEDICARE** when **MEDICARE** entitlement precedes termination of coverage - 36 months. This 36 month period begins on the day the **COVERED EMPLOYEE** becomes entitled to **MEDICARE**, or eighteen (18) months from the Qualifying Event, whichever is greater, whether or not he remains covered under this **PLAN**.
5. **DEPENDENT** children who lose **DEPENDENT** status as defined by this **PLAN** - 36 months.
6. A **COVERED EMPLOYEE,** who loses coverage for the purposes of performing uniformed services, and his **COVERED DEPENDENTS** may elect to continue coverage for the lesser of twenty-four (24) months beginning on the date of the **EMPLOYEE'S** absence for the purpose of performing uniformed services or the date on which the period of absence begins and ending on the date on which the **EMPLOYEE** fails to return to uniformed service or applys for a position of employment.

NOTE:
*In case of multiple events, an original Qualifying Event is the **EMPLOYEE'S** termination of employment or reduction in hours, (resulting in an 18 month maximum period of continuation coverage), then the occurrence of another Qualifying Event during that 18 month period will permit the Qualified Beneficiary to continue coverage for up to 36 months after occurrence of the first Qualifying Event.*

- **Premium Requirements and Payment Of Premium**

A Qualified Beneficiary is required to pay for **CONTINUATION OF COVERAGE**. The Qualified Beneficiary can be charged 102% of the **EMPLOYER**'S cost of the coverage, except in the case of a disabled Qualified Beneficiary who is disabled at the time of termination of employment can be charged 150% of the **EMPLOYER**'S cost during the 19th through 29th month of continued coverage. Coverage may cease if timely premium payments are not made. To prevent a lapse in coverage, the Qualified Beneficiary who elects **CONTINUATION OF COVERAGE** after the Qualifying Event is permitted to pay within forty-five (45) days of election any premiums owed for **CONTINUATION OF COVERAGE** during the period preceding the election. Payment received later than the stated forty-five (45) days after the election date are not timely and coverage will not be provided.

The payment of any subsequent premiums shall be considered timely if they are post-marked not later than thirty (30) days after premium is due. The **PLAN ADMINISTRATOR** should be contacted for the current contribution rate.

- **Termination Of Continuation Coverage**

CONTINUATION OF COVERAGE cannot terminate before the earliest of the following dates:

1. The last day of the required maximum period of coverage (18 or 36 month coverage periods);
2. The first day the Qualified Beneficiary fails to pay the premium on a timely basis, as stated above;
3. The date on which the **EMPLOYER** ceases to provide group health coverage to any of its **EMPLOYEES**;
4. The first date after the date of election on which the Qualified Beneficiary is actually covered (not just eligible) under any other group health plan.

5. The date that the Qualified Beneficiary is covered by **MEDICARE** (thus, retirees who become covered under **MEDICARE** do not have to be provided with CONTINUATION OF COVERAGE), except in the case of entitlement to **MEDICARE** due to End Stage Renal Disease which allows the Qualified Beneficiary to continue coverage until any of the other conditions for termination of **CONTINUATION OF COVERAGE** are met;
6. Only for a disabled Qualified Beneficiary during their 19th through 29th month of continued coverage, the first of the month following thirty (30) days after the date of the final determination from social security that the Qualified Beneficiary is no longer disabled.

- **Bankruptcy**

If this **PLAN** provides benefits for **RETIREE**S and if this **PLAN** eliminates or substantially reduces the coverage that the **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** would otherwise have within one year before or after the date the **EMPLOYER** begins a bankruptcy proceeding, the **COVERED EMPLOYEE** and/or **COVERED DEPENDENT(S)** also has the right to continue coverage under this **PLAN** at their expense. The procedure for continuing coverage and the premium is the same as stated above. Coverage will continue until the earliest of the following:

1. The date on which a premium payment was due but not paid;
2. The date the **EMPLOYER** terminates all of its group health plans.
3. The date the person continuing coverage dies;
4. Thirty-six (36) months from the date the **COVERED EMPLOYEE** dies.
5. The date the person continuing coverage becomes covered by another employer's group health plan.

This **PLAN**, upon receipt of proof that a **COVERED PERSON** incurred a **MEDICALLY NECESSARY** REASONABLE eligible **COVERED EXPENSE** as the result of **INJURY** or **ILLNESS**, shall consider the **USUAL AND CUSTOMARY** fees up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable).

- **Inpatient Hospital Expense** (including Physician charges)

  Expenses in connection with **MEDICALLY NECESSARY** and **REASONABLE** inpatient **HOSPITAL** confinement including **SEMI-PRIVATE ROOM AND BOARD**, **SPECIAL CARE UNITS** and necessary services and supplies shall be considered at the **USUAL AND CUSTOMARY** fees not exceeding the maximum benefit as stated in the SCHEDULE OF BENEFITS. After twenty-three (23) observation hours a confinement will be considered an in-patient confinement.

- **Outpatient Hospital Expense** (including Physician charges)

  Expenses in connection with **MEDICALLY NECESSARY** and **REASONABLE** outpatient care shall be considered at the **USUAL AND CUSTOMARY** fees not exceeding the maximum benefit as stated in the SCHEDULE OF BENEFITS.

- **Surgical Day Care** (including Physician charges)

  Expenses in connection with **MEDICALLY NECESSARY** and **REASONABLE** services performed in the surgical day care unit of a facility shall be considered at the **USUAL AND CUSTOMARY** fees not exceeding the maximum benefits as stated in the SCHEDULE OF BENEFITS.

- **Extended Care Facility / Skilled Nursing Facility / Rehabilitation Facility Expenses**

  Expenses for **MEDICALLY NECESSARY** and **REASONABLE** services performed in an **EXTENDED CARE / SKILLED NURSING FACILITY/REHABILITATION FACILITY** shall be considered at the **USUAL AND CUSTOMARY** fees, not exceeding the maximum benefits as stated in the SCHEDULE OF BENEFITS providing the following conditions have been met:

  1. If after being **HOSPITAL**-confined for three consecutive days or more, and within fourteen (14) consecutive days of termination of that confinement, the **COVERED PERSON** becomes confined in the **EXTENDED CARE / SKILLED NURSING FACILITY / REHABILITATION FACILITY**. If it is determined appropriate care for the **COVERED PERSON**, the requirement of being **HOSPITAL** confined for three (3) consecutive days may be waived, and;
  2. If the attending **PHYSICIAN** certifies twenty-four (24) hour nursing care is **MEDICALLY NECESSARY** for recuperation from the **INJURY** or **ILLNESS** which required the **HOSPITAL** confinement. Payment will continue for as long as **MEDICALLY NECESSARY** and **REASONABLE** and as stated in the SCHEDULE OF BENEFITS.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Hospice Benefit

Expenses for **MEDICALLY NECESSARY** and **REASONABLE** inpatient and in-home services shall be considered at the **USUAL AND CUSTOMARY** fees not exceeding the maximum benefit as stated in the SCHEDULE OF BENEFITS.

A Hospice in-home program means a coordinated, interdisciplinary program approved by the terminally ill person's attending **PHYSICIAN**.

Benefits for **HOSPICE** care will be considered only when the following conditions are met:

- The **COVERED PERSON** has a terminal **ILLNESS** with a life expectancy of six (6) months or less, as certified by a **PHYSICIAN**.
- The **COVERED PERSON** and attending **PHYSICIAN** have consented to a plan of care emphasizing pain control and symptom relief rather than curative treatment.
- An adult functions as the primary care person in the home.

Inpatient services in a **HOSPICE** will be treated as a confinement in a general **HOSPITAL**. Inpatient services in a **HOSPICE** for respite care only will be considered under **HOSPITAL** benefits for a maximum of five (5) days only.

Outpatient services rendered by a participating **HOSPICE** provider will be considered the same as nursing services, unless otherwise stated in the Schedule of Benefits. Bereavement services will be provided to **COVERED PERSON**S following the death of the **HOSPICE** patient.

A wide range of inpatient and in-home services, including prescription drugs, medical supplies, and **DURABLE MEDICAL EQUIPMENT** may also be available to be considered.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred a **MEDICALLY NECESSARY** and **REASONABLE** surgical procedure performed by a **PHYSICIAN** as a result of **INJURY** or **ILLNESS**, shall consider the **USUAL AND CUSTOMARY** fees up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable).

- **Multiple Procedures**

If two or more Surgical Procedures are performed at one time through the same incision or in the same operative field, the maximum amount considered for surgery will be the **USUAL AND CUSTOMARY** expense for the major procedure and 50% for the secondary or lesser procedure, 25% of the **USUAL AND CUSTOMARY** expense for the third, 10% of the **USUAL AND CUSTOMARY** expense for the fourth, and 5% of the **USUAL AND CUSTOMARY** expense for each additional procedure performed. NOTE: Physician review and/or contractual agreements may be applicable in lieu of the above.

- **Assistant Surgeons**

Provided an assistant surgeon is **MEDICALLY NECESSARY** for a surgical procedure, the allowable fee for the assistant surgeon will be determined by using 20% of the **USUAL AND CUSTOMARY** fee for the surgery.

- **Second Surgical Opinion**

A benefit will be provided for a second surgical opinion and a third and final surgical opinion if needed, performed only by a board-certified Surgeon who, by the nature of the Surgeon's specialty, qualifies the Surgeon to consider the operation being proposed. The Surgeon performing the second and third opinions must examine the **COVERED PERSON** before that **COVERED PERSON** enters the **HOSPITAL** or the place where the surgery is to be performed except in the case of **EMERGENCY** surgery. The Surgeon must furnish the opinion in writing, and must not be in any way financially associated with the Surgeon who first recommended the surgery. It is required that opinions be obtained from two board-certified Surgeons. If your regular **PHYSICIAN** is not a Surgeon but refers you to a board-certified Surgeon for an opinion, the opinion of the regular **PHYSICIAN** does not constitute a surgical opinion.

- **Anesthesia**

Units are defined as 15 minutes. Partial units will be converted to the nearest 0.1 unit.

Certified Registered Nurse Anesthetists (CRNA) & Anesthesia Assistants (AA):
CRNAs: Non-supervised CRNAs or AAs will be reimbursed at 85% of the physician anesthesiologist rate. Supervised CRNAs or AAs will be reimbursed at 50% of the physician anesthesiologist rate; as will the supervising physician anesthesiologist.

Epidural Anesthesia: Epidural anesthesia for labor will be reimbursed at base units plus actual patient contact time. In absence of adequate documentation of contact time, epidural anesthesia for labor will be reimbursed at base plus 2 units for insertion, plus 1 unit per hour.

Epidural for delivery or C-section will be reimbursed at actual contact time; when follow on to epidural labor, no additional base units will be reimbursed. NOTE: Physician review and/or contractual agreements may be applicable in lieu of the above.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Diagnostic X-Ray And Laboratory Benefit

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred **MEDICALLY NECESSARY** and **REASONABLE COVERED EXPENSES** as a result of **INJURY** or **ILLNESS** for diagnostic X-ray or laboratory examination, made or recommended by a **PHYSICIAN**, shall consider the **USUAL AND CUSTOMARY** fees by the **PHYSICIAN** and Laboratory up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable).

Tests and other services that are automatically performed as a panel, group or set, may be determined by the **PLAN ADMINISTRATOR** to be paid as a single service in the **PLAN ADMINISTRATOR's** discretion. The **PLAN ADMINISTRATOR** has sole discretionary authority to determine the applicability of this provision to determine whether unbundling has occurred and to select vendors to identify instances of unbundling.

Separate professional fees will not be reimbursed for laboratory tests unless there is a written order for a consultation by the attending physician, the pathologist provides a written report back to the attending physician, and the consultation is **MEDICALLY NECESSARY**.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Mental & Nervous Disorder, Alcoholism, Chemical Dependency & Substance Abuse Addiction Benefit

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred **MEDICALLY NECESSARY** and **REASONABLE COVERED EXPENSES** for the treatment of mental and nervous disorders, alcoholism, chemical dependency and substance abuse shall consider the **USUAL AND CUSTOMARY** fees up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable).

Partial day or evening programs may be approved in lieu of an inpatient admission. If approved by the **PLAN ADMINISTRATOR**, **PLAN SPONSOR** or Review Board, coverage for these programs will be considered at the inpatient level of benefits allowing for two (2) days of partial as one (1) inpatient day and four (4) days of evening as one (1) inpatient day.

PHYSICIAN visits for medication management will be considered separately and will not accumulate towards the mental and nervous disorder benefit annual or period of coverage maximums.

Psychotherapeutic programs directed toward improving compliance with prescribed medical treatment regimens for such chronic conditions as diabetes, hypertension, ischemic heart disease and emphysema.

Family, couples, individual and group outpatient therapy are eligible services.

All requirements of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time, will be adhered to.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Dental / Surgery Expense Benefit

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred **MEDICALLY NECESSARY** and **REASONABLE COVERED EXPENSES** as a result of **INJURY** or **ILLNESS** for the following dental related services, shall consider the **USUAL AND CUSTOMARY** fees up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable).

The following dental related services will be considered under the Surgery Expense Benefit:

1. Treatment of an **INJURY** to a sound natural tooth, other than from eating or chewing, or treatment of an **INJURY** to the jaw due to an **INJURY**.

2. Excision of tumor, cyst, or foreign body of the oral cavity and related anesthesia.

3. Biopsies of the oral cavity and related anesthesia.

4. Removal of partially bony and full bony impacted teeth, and related anesthesia.

5. **MEDICALLY NECESSARY** treatment of the temporomandibular joint.

If a **COVERED PERSON** has a serious medical condition that requires hospitalization or treatment in an **AMBULATORY SURGICAL CENTER** for dental services other than those listed above, only the **HOSPITAL** or **AMBULATORY SURGICAL CENTER** charges and not the dentist or anesthesiologist's charges will be considered.

PRIOR TO ANY NON-EMERGENCY TREATMENT, THE DENTIST MUST SUBMIT A WRITTEN DETAILED PRE-TREATMENT ESTIMATE FOR SERVICES EXPECTED TO EXCEED $400.00

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Organ Transplant Benefit

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred **MEDICALLY NECESSARY** and **REASONABLE COVERED EXPENSES** related to any of the following surgical procedures for an **ORGAN TRANSPLANT**, shall consider the **USUAL AND CUSTOMARY** fees up to the maximum as stated in the SCHEDULE OF BENEFITS, subject to the **DEDUCTIBLE** and **CO-INSURANCE** (if applicable), and further subject to the following limitations:

Covered Organ Transplants, including but not limited to:

Human Heart Transplant	Kidney Transplant
Bone Marrow Transplant	Cornea Transplant
Heart and Lung Transplant	Liver Transplant
Lung Transplant	Pancreas Transplant

All **EXPERIMENTAL** and/or not **MEDICALLY NECESSARY ORGAN TRANSPLANTS** are not covered by this **PLAN**.

a. A second opinion must be obtained prior to any transplant procedure. The mandatory second opinion must concur with the attending **PHYSICIAN'S** findings regarding the medical necessity of the transplant. The second opinion must be rendered by a board certified surgeon in the appropriate specialty who is not professionally or financially associated with the **PHYSICIAN** who rendered the first surgical opinion. The **PHYSICIAN** who gives the second surgical opinion may not perform the surgery. This requirement may be waived based on plan and/or independent review.
b. All **ORGAN TRANSPLANTS** must be pre-approved by the **PLAN ADMINISTRATOR** or its designee. Failure to obtain pre-approval will result in a denial of all transplant related expenses. Note that pre-certification is not the same as pre-approval. Call GISC at 800-242-4472 with questions.
c. The **REASONABLE AND CUSTOMARY** expenses for securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and the **HOSPITAL'S** charge for storage and/or transportation of the organ, will be considered a **COVERED EXPENSE**.
d. If the transplant recipient is covered under this **PLAN**, eligible medical **EXPENSES INCURRED** by the recipient will be considered for benefits. **EXPENSES INCURRED** by the donor, who is not ordinarily covered under this **PLAN** according to **COVERED PERSON** eligibility requirements, will be considered **ELIGIBLE EXPENSES** to the extent that such expenses are not payable by the donor's healthcare plan. In no event will the total of benefits paid for recipient and donor combined be in excess of the maximum benefit available to the individual who is a **COVERED PERSON** under this **PLAN**.
e. If both the transplant donor and the transplant recipient are covered under this **PLAN**, eligible medical **EXPENSES INCURRED** by each **COVERED PERSON** will be treated separately.
f. If the transplant donor is covered under this **PLAN**, eligible medical expenses incurred by the donor will be considered for benefits to the extent donor benefits are not provided under the transplant recipient's health plan.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

This **PLAN**, upon receipt of proof that a **COVERED PERSON** has incurred **MEDICALLY NECESSARY** and **REASONABLE COVERED EXPENSES** as a result of **INJURY** or **ILLNESS**, shall consider the **USUAL AND CUSTOMARY** fees charged up to the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations (if applicable). The benefits payable shall not exceed the annual maximum and are subject to all limitations and conditions of this **PLAN**.

- **Medical Deductible Amount**

The amount which the **COVERED PERSON** must pay in each **CALENDAR YEAR** before **PLAN** Major Medical Benefits become payable. This amount is stated in the SCHEDULE OF BENEFITS.

If, during a **CALENDAR YEAR**, **DEDUCTIBLES** have been satisfied by **COVERED PERSONS** who are members of the same family, and if the sum of the credited **DEDUCTIBLES** is equal to the family **DEDUCTIBLE** shown in the SCHEDULE OF BENEFITS, the **DEDUCTIBLE** has therefore been met for any remaining members of that family for additional **COVERED EXPENSES INCURRED** during that **CALENDAR YEAR**.

If during the last three (3) months of a **CALENDAR YEAR**, a **COVERED PERSON** incurs **MEDICALLY NECESSARY COVERED EXPENSES** applicable to the **DEDUCTIBLE**, such expenses shall also be applicable to the **DEDUCTIBLE** for the next succeeding **CALENDAR YEAR**. This carryover provision only applies to individual **DEDUCTIBLES**.

The following **MEDICALLY NECESSARY** and **REASONABLE** covered expenses may be subject to the **DEDUCTIBLE** and **CO-INSURANCE** limitations and the maximum as stated in the SCHEDULE OF BENEFITS and further subject to the medical providers listed under **COVERED PROVIDERS** in the Definitions Section.

1. Expenses for **HOSPITAL ROOM AND BOARD** and **IN-HOSPITAL MISCELLANEOUS EXPENSES**, excluding expenses in excess of the **ROOM AND BOARD** maximum benefit as stated in the SCHEDULE OF BENEFITS;
2. Expenses for **SPECIAL CARE UNITS OF HOSPITAL**S;
3. Expenses for outpatient **HOSPITAL** expenses and **AMBULATORY SURGICAL CENTERS**;
4. Expenses for **HOSPICE** services;
5. Expenses for surgery and other medical care and treatment by a **PHYSICIAN** or **COVERED PROVIDER**;
6. Expenses for anesthesia and its administration;
7. Expenses for nursing care prescribed by the attending **PHYSICIAN**, and rendered by a **REGISTERED NURSE** (RN) or a **LICENSED PRACTICAL NURSE** (LPN); but only for nursing duties, and excluding all domestic activities;
8. Expenses for physiotherapy/physical therapy provided such treatment is recommended by the attending **PHYSICIAN,** unless specified in the **SCHEDULE OF BENEFITS**;
9. Expenses for restorative or rehabilitative speech, occupational or cognitive therapy related to an impairment due to an **ILLNESS** or **INJURY**, other than a functional nervous disorder or due to surgery performed for an **ILLNESS** or **INJURY** provided such treatment is prescribed by the attending **PHYSICIAN**, excluding therapy for developmental delays, unless specified in the SCHEDULE OF BENEFITS;
10. Expenses for the diagnosis and treatment of autism spectrum disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first. Treatment includes: habilitative or rehabilitative care; pharmacy care; psychiatric care; psychological care; and therapeutic care (includes services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers), if the physician or psychologist determines the care to be medically necessary;
11. Expenses for necessary ground ambulance transportation or for medical emergency ambulance flights (such as med-evac or air ambulance) to re-locate a patient for emergency treatment of a life threatening **ILLNESS** or **INJURY** which necessitates immediate medical attention. All types of ambulance are only covered for transport to the nearest **HOSPITAL** equipped to furnish the treatment or from one **HOSPITAL** to another while an in-patient;
12. Expenses for laboratory tests, X-ray treatments and X-ray examinations when recommended by the attending **PHYSICIAN** and **COVERED PROVIDER**;
13. Expenses for **MEDICALLY NECESSARY** appliances prescribed by the attending **PHYSICIAN** and which correct or alleviate the **ILLNESS** or **INJURY** such as casts, splints, trusses, orthopedic braces, crutches, prescribed traction equipment, artificial limbs, a breast prosthesis following a mastectomy, or artificial eyes and eyewear when necessary as the direct result of surgery on the eye;
14. Expenses for the **MEDICALLY NECESSARY** replacements of a medical prosthesis or orthopedic brace which is no longer serviceable, as long as there is a change in condition, such as growth, or the prosthesis or brace that is being replaced is at least five (5) years old;
15. Expenses for **MEDICALLY NECESSARY** specially molded orthopedic shoes, and/or specially molded orthopedic inserts prescribed by the attending **PHYSICIAN**, limited to one (1) pair per **COVERED PERSON** per **CALENDAR YEAR**;

16. Expenses for any treatment, service, or supply for nicotine use or nicotine addiction, as mandated by **PPACA**;

17. Expenses for wigs for hair loss resulting from the treatment of cancer, limited to one (1) per **COVERED PERSON** every five (5) consecutive years;

18. Expenses for mastectomy bras, limited to two (2) per **COVERED PERSON** per **CALENDAR YEAR**;

19. Expenses for the rental, purchase and repair of **DURABLE MEDICAL EQUIPMENT** such as oxygen equipment, wheelchairs, special **HOSPITAL** beds, medical supplies prescribed by a **PHYSICIAN**, or other mechanical equipment necessary for the treatment of the patient. Coverage is limited to the least expensive item which is adequate for the patient's needs, and the rental will not exceed the purchase price of the appliance or mechanical equipment;

20. Expenses for Home Health Care rendered to a **COVERED PERSON** by a **HOME HEALTH AGENCY** for the following **MEDICALLY NECESSARY** services and supplies that are furnished in the **COVERED PERSON**'S home in accordance with this **PLAN**, as prescribed by the **PHYSICIAN.** One visit is equal to four (4) hours.

    MEDICALLY NECESSARY services and supplies are:
    a. Part-time or intermittent nursing care by or under the supervision of a **REGISTERED NURSE** (RN); or
    b. Part-time or intermittent certified home health aide services or nursing care by a **LICENSED PRACTICAL NURSE** (LPN) which consist primarily of caring for the patient; or
    c. Physical therapy, occupational therapy, and speech therapy provided by the **HOME HEALTH AGENCY**; or
    d. Medical supplies, drugs, and medications prescribed by a **PHYSICIAN** and laboratory services by or on behalf of a **HOSPITAL** to the extent such items would have been considered by this **PLAN** had the **COVERED PERSON** remained in the **HOSPITAL**;

21. Expenses for outpatient radiation therapy, chemotherapy, electroshock therapy, or hemodialysis (renal therapy) at a **MEDICARE** approved dialysis center;

22. Expenses for drugs and medicines (including insulin, contraceptives and **PPACA** mandates) legally obtainable only upon written prescription by a **PHYSICIAN** and dispensed by a licensed pharmacist, excluded over-the-counter medications may be allowed when prescribed and considered a part of the prescription step therapy program;

23 Expenses for diabetic and ostomy supplies;

24. Expenses for registered dieticians for the initial dietary consultation in relation to medical conditions, such as heart conditions, diabetes and bulimia;

25 Expenses for routine colonoscopy performed to rule out cancer because of family history or provided the **COVERED PERSON** is a minimum of fifty (50) years old. The **PLAN** will follow the guidelines of the **PPACA**;

26 Expenses for **ROUTINE CARE**, **WELL CHILD CARE**, and routine immunizations and vaccinations, excluding physical examinations required for a work permit, insurance or employment;

27 Expenses for or relating to preventive services in accordance with **PPACA** guidelines;

28 Expenses for surcharges under NY Health Care Reform Act provided the Plan/Employer is enrolled in the pool and under Massachusetts Act C.47.

29 Expenses for genetic testing needed to determine a treatment plan for the **COVERED PERSON** or mandated by **PPACA**.

30 Expenses for medical case management, negotiations and/or independent medical reviews.

31 Expenses for eye exams, limited to one per **CALENDAR YEAR** for **COVERED PERSONS** over the age of nineteen (19). **COVERED DEPENDENTS** up to age nineteen (19) will be provided benefits outlined in **CHIPRA**.;

32 Expenses for newborn **WELL BABY CARE** by the **HOSPITAL**;

33 Expenses for newborn **WELL BABY CARE** by the **PHYSICIAN**, including circumcision;

34 Expenses for tubal ligation or vasectomy if elective sterilization;

35 Expenses for a diagnosis of infertility will be considered the same as any other **ILLNESS**.

36 Expenses for charges related to reverse sterilization, limited to one attempt;

37 Expenses for services rendered by a Chiropractor;

38 Expenses for **MEDICALLY NECESSARY** services related to treatment of the temporomandibular joint;

39 Expenses related to pregnancy of **DEPENDENT** children;

40 Expenses for the dental related surgical services listed under the Dental Surgery Benefit;

41 Expenses for family and couple therapy;

42 Expenses for services rendered by a licensed **EXTENDED CARE FACILITY**, **SKILLED NURSING FACILITY**, or **REHABILITATION FACILITY** after being **HOSPITAL** confined for three (3) consecutive days or more, and within fourteen (14) consecutive days of termination of that confinement when the attending **PHYSICIAN** certifies twenty-four (24) hour nursing care is necessary for recuperation from the **INJURY** or **ILLNESS** which required the **HOSPITAL** confinement, not to exceed the maximum limit as stated in the SCHEDULE OF BENEFITS;

43 Expenses for unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered;

44 Expenses for eye exams for the treatment of any muscle disorders of the eye, (e.g. esotropia and strabismus), limited to one office or clinic visit per **COVERED PERSON** per **CALENDAR YEAR**, unless surgery to correct the condition is scheduled. Expenses for muscle training, orthoptics and refractions are not covered by the **PLAN**.

45 Expenses for growth hormones when prescribed by a board certified pediatric endocrinologist and a written treatment plan is submitted for approval to the **PLAN ADMINISTRATOR**.;

46 Expenses for prescription or non-prescription formula, which has been prescribed by a **PHYSICIAN** and determined **MEDICALLY NECESSARY** for treatment of an inherited metabolic disease or those administered through a feeding tube.

47 Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under the ACA, provided:

a. The clinical trial is approved by:
    i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
    ii. The National Institute of Health;
    iii. The U.S. Food and Drug Administration;
    iv. The U.S. Department of Defense;
    v. The U.S. Department of Veterans Affairs; or
    vi. An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
d. A cost associated with managing an Approved Clinical Trial;
e. The cost of a health care service that is specifically excluded by the Plan; or
f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

LIMITATIONS:
The GENERAL LIMITATIONS AND EXCLUSIONS apply to this Benefit.

Except where otherwise specifically indicated to the contrary, no consideration shall be made under any benefit of this **PLAN** for **EXPENSES INCURRED** in connection with:

1. Expenses that are not payable under the **PLAN** due to application of any **PLAN** maximum or limit or because the charges are in excess of the **USUAL AND CUSTOMARY** amount, or are for services not deemed to be **REASONABLE** or **MEDICALLY NECESSARY**, based upon the **PLAN ADMINISTRATOR's** determination as set forth and within the terms of this **PLAN**;
2. Expenses for any confinement, treatment, service, or supply not **MEDICALLY NECESSARY** whether or not recommended and approved by a **PHYSICIAN** or **COVERED PROVIDER**;
3. Expenses for any confinement, treatment, service or supply except while under the regular care and treatment of a **PHYSICIAN** or **COVERED PROVIDER**;
4. **EXPENSES INCURRED** in connection with any condition for which a **COVERED PERSON** receives or is entitled to receive, whether by settlement or by adjudication, any benefit under Worker's Compensation or Occupational Disease Law or similar law, or which is in connection with employment for wage or profit of any kind. This exclusion would also apply if a **COVERED PERSON** were providing their normal employment for wage or profit to another party as a trade for their services and/or supplies. This exclusion does not apply to incidental activities performed by **COVERED PERSONS**, such as newspaper delivery, baby-sitting, caddying or lawn care;
5. **EXPENSES INCURRED** which are not for treatment of an **ILLNESS** or **INJURY**.
6. Expenses for services rendered by a medical provider who is not listed as a **COVERED PROVIDER** under the Definitions Section of the **PLAN**, or for providers not acting within the scope of their license.
7. Expenses for an **ILLNESS** or **INJURY** sustained as a result of a major disaster, war, or epidemic. In the event of a natural disaster, war, riot, civil insurrection, epidemic or any other **EMERGENCY**, the obligations of the **EMPLOYER** under this **PLAN** shall be limited to making a good-faith effort to provide or arrange for the provision of the benefits covered by this **PLAN**. No benefits shall be provided for **INJURIES** or **ILLNESS** resulting from active duty in the military services of any country, combination of countries, or international authority;
8. Expenses for **COSMETIC SURGERY** and expenses by the **PHYSICIAN**, **PHYSICIANS** or **COVERED PROVIDERS** performing the **COSMETIC SURGERY**, including treatment of acne scarring, except for **MEDICALLY NECESSARY** treatment of a congenital abnormality in a **CHILD**;
9. Expenses for **RECONSTRUCTIVE SURGICAL PROCEDURES**, except for **MEDICALLY NECESSARY** treatment of an **ILLNESS**, or treatment of an **INJURY**;
10. Expenses for speech therapy, except when a normal speech pattern is modified by an **ILLNESS**, or **INJURY**;
11. Expenses for occupational and cognitive therapy when it is not a constructive therapeutic activity designed and adapted to promote the restoration of useful physical function;
12. Expenses for any inpatient admission when the care provided is only **CUSTODIAL CARE**, or when the nature of the patient's condition or services being provided do not require that the patient be treated as an inpatient;
13. Expenses for services which are not related to the condition for which the patient is receiving treatment or which principally consist of bed rest or isolation from the patient's usual environment;
14. Expenses for personal comfort or beautification items, radio, telephone, television, education, educational aids or training;

15. Expenses for time spent traveling or for expenses connected to traveling that may be incurred by a **PHYSICIAN**, **COVERED PROVIDER**, or **COVERED PERSON** in the course of rendering services;
16. Expenses for **EXPERIMENTAL** medical, surgical, or other health care procedures or services that are not widely recognized procedures by the AMA, or for any services or supplies not considered legal in the United States. Unless indicated elsewhere, no benefits shall be provided for over-the-counter drugs and medicines or those not approved for general use by the FDA, including tests which are investigational;
17. Expenses for sex therapy, or for transsexual surgery and related pre-operative and post-operative procedures or complications, which, as their objective, change the person's sex;
18. Expenses for treatment, services, or supplies provided by a **PHYSICIAN** or **COVERED PROVIDER** who ordinarily resides with the **COVERED PERSON** or is the **COVERED PERSON**, including, but not limited to, his spouse, children, brother, sister or parent;
19. Expenses for services or treatment of behavioral problems, learning disabilities, or developmental delays when received without a medical diagnosis, including but not limited to Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, Autism and Early Intervention unless stated otherwise in SCHEDULE OF BENEFITS or COVERED MEDICAL EXPENSES in this **PLAN**;
20. Expenses for services rendered in a VA **HOSPITAL** for any military service related **ILLNESS** or **INJURY**;
21. Expenses for surgery or supplies for correction of refractive errors, including radial keratotomy and refractive keratoplasty;
22. **EXPENSES INCURRED** from **INJURIES** sustained by the **COVERED PERSON** during the commission of or attempt to commit a felony, or while engaged in an illegal activity or aggravated assault;
23. Expenses for chelation therapy, unless independent physician review determines it is the appropriate **MEDICALLY NECESSARY** treatment;
24. Expenses for purchase or rental of common-use supplies, such as exercise cycles, air purifiers, air conditioners, water purifiers, hypo-allergenic pillows or mattresses or waterbeds;
25. Expenses for tax or shipping expenses charged on **DURABLE MEDICAL EQUIPMENT** or drugs; or for interest charged by a **COVERED PROVIDER**;
26. **EXPENSES INCURRED** for which the **COVERED PERSON**, in the absence of this coverage, is not legally obligated to pay or for which a charge would not ordinarily be made in the absence of this coverage;
27. Expenses for orthopedic shoes, arch-supports, or for the exam, prescription or fitting thereof for splints or braces, when the primary purpose is for use in sports participation or similar physical activities, even if prescribed by the attending **PHYSICIAN**;
28. Expenses for failure to keep a scheduled visit or charges for completion of a claim form;
29. Expenses for concurrent inpatient services of **PHYSICIANS**, unless there is a clinical necessity for supplemental skills or the two or more **PHYSICIANS** attend the patient for separate conditions during the same **HOSPITAL** admission;
30. Expenses for periodontal splinting, appliance insertion or restoration when used to increase vertical dimension and expenses for precision attachments;
31. Expenses for any medical services related to surrogate parenting;

32. Expenses for court ordered treatment;
33. Expenses for myofunctional therapy or correction of harmful habits, other than treatment for chemical dependency or alcoholism or substance abuse;
34. Expenses for medical services rendered outside of the United States if treatment is available within the United States and the sole purpose of traveling is to obtain such services;
35. Expenses for health, swim club and tanning club memberships for any reason;
36. Expenses for genetic counseling, testing and related services, unless required under Federal Law as amended from time to time or to determine a treatment plan for the **COVERED PERSON**;
37. Expenses for massage therapy, acupuncture, hypnotherapy, rolfing and homeopathic remedies, unless stated otherwise in the Schedule of Benefits;
38. Expenses for treatment and/or placement in a residential treatment facility, unless approved through Case Management or Independent Physician Review;
39. Expenses for Saturday, and Sunday admissions, unless for an **EMERGENCY.** A Sunday admission will be allowed as long as you are admitted less than twenty-four (24) hours prior to your scheduled surgery;
40. Expenses for medication which has been approved by the Food and Drug Administration, but is not considered **MEDICALLY NECESSARY.** Expenses for "off-label" use will be considered based on **MEDICAL NECESSITY**;
41. Expenses for, and related to, surgery performed which utilizes equipment or machines which have not been approved by the Food and Drug Administration or are still in the investigational period;
42. Expenses for **HOSPITAL** and anesthesia charges incurred to perform dental surgery unless the **COVERED PERSONS** has a serious medical condition;
43. Expenses for care, supplies, treatment, and/or services that are provided to a **COVERED PERSON** for which the **PROVIDER** of a service customarily makes no direct charge, or for which the **COVERED PERSON** is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the **COVERED PERSON** or this benefit plan, ***may be liable*** for necessitating the fees, care, supplies, or services;
44. Expenses for care, supplies, treatment, and/or services that are not actually rendered;
45. Expenses for care, supplies, treatment, and/or services that are rendered or received prior to or after any annual maximum hereunder, except as specifically provided herein;
46. Expenses for care, supplies, treatment and/or services of an **INJURY** or **ILLNESS** not payable by virtue of the PLAN's subrogation, reimbursement and/or third party responsibility provisions;
47. Expenses for hearing devices, eye refractions, eyeglasses, contact lenses or their fitting, except for intraocular implant of lenses in the treatment of cataracts, or for the initial eyewear following cataract surgery;
48. Expenses related to artificial insemination, in vitro fertilization (IVF) or gamete intrafallopian transfer (GIFT);
49. Expenses for medications to restore or enhance fertility;

50. Expenses for services and supplies related to sexual dysfunctions or inadequacies regardless of the cause, inclusive of medication to treat erectile dysfunction, unless the dysfunction is a direct result of surgery;
51. Expenses for the **ROUTINE CARE** of bunions, corns, callouses, toenails, flat feet, fallen arches, chronic foot strain, or symptomatic complaints related to the feet unless corrected by a major surgical procedure;
52. **EXPENSES INCURRED** for nutritional supplements or as services required for a work permit, insurance or employment;
53. Expenses for **COSMETIC SURGERY** and for any other condition treated simultaneously by the **PHYSICIAN**, **PHYSICIANS** or **COVERED PROVIDER**, including treatment of acne scarring;
54. Expenses for the donor involved in an **ORGAN TRANSPLANT**; Donor may be covered if recipient is **EMPLOYEE**. See Organ Transplant page;
55. Expenses for pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies;
56. Expenses for services related to treatment of obesity, weight reduction, nutritional supplements or dietary control, except for the initial diagnostic examination and related tests for expenses related to the surgical treatment of morbid obesity which is determined to be in excess of 70% of standard weight tables;
57. Expenses for unreplaced blood and blood plasma;
58. Expenses for orthoptics, (muscle strengthening for eye disorders) and any other services relating to this type of treatment;
59. Expenses for growth hormones which have not been pre-approved.
60. Expenses for prescription or non-prescription formula, unless deemed medically necessary by a physician.
61. Expenses for services, supplies, care or treatment to a **COVERED PERSON** for **INJURY** or **ILLNESS** resulting from that **COVERED PERSON'S** voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, narcotic or other substance not administered on the legal advice of a **PHYSICIAN**. Expenses will be covered for injured **COVERED PERSONS** other than the person using illegal drugs, medications or other substances.

Medicare Provision

Whenever **MEDICARE** is determined by federal statute to be the primary payor of benefits for a **COVERED PERSON** under this **PLAN**, any benefits of this **PLAN** will be coordinated with **MEDICARE** in accordance with the **COORDINATION OF BENEFITS** Provision of this **PLAN**. Whenever **MEDICARE** is determined by federal statute to be the secondary payor of benefits for a **COVERED PERSON** under this **PLAN**, any benefits of this **PLAN** will be supplemented with **MEDICARE** in accordance with the **COORDINATION OF BENEFITS** Provision of this **PLAN**.

An active **COVERED EMPLOYEE** and his spouse, over age 65 and eligible for **MEDICARE**, or a disabled **EMPLOYEE** who is a **MEDICARE** beneficiary, may reject coverage in this **PLAN** and rely on **MEDICARE** as the sole source of coverage. If the **COVERED EMPLOYEE** does not reject coverage in this **PLAN**, he will have coverage in both this **PLAN** and **MEDICARE**, and **MEDICARE** will be secondary if the **EMPLOYER** normally employs twenty (20) or more **EMPLOYEE**S. If he is not an active **COVERED EMPLOYEE**, **MEDICARE** will be primary for him and his spouse. If he accepts coverage under this **PLAN**, all bills should be filed initially with this **PLAN**; if he rejects this **PLAN**, file all bills to **MEDICARE**.

MEDICARE is also available to certain people who have not yet reached age 65, but who have received social security disability benefits for twenty-four (24) months. When **MEDICARE** is available in these situations, this **PLAN** will be primary as long as the **EMPLOYER** normally employs more than 100 **EMPLOYEE**S on a typical business day; otherwise this **PLAN** will be secondary. If the **EMPLOYER** normally employs less than 100 **EMPLOYEE**S on a typical business day, **MEDICARE** will be primary and this **PLAN** will be secondary. If the **EMPLOYER** has more than 100 **EMPLOYEES**, all bills should be filed initially with this **PLAN**; if less than 100 **EMPLOYEES**, file all bills initially to **MEDICARE**.

MEDICARE is also available to a **COVERED PERSON** who has been on dialysis for end stage renal disease for three (3) consecutive months or the month he is admitted to a **MEDICARE** approved **HOSPITAL** for a kidney transplant if the transplant takes place in that month or within the two (2) following months. This **PLAN** will be primary to **MEDICARE** for a **COVERED PERSON** who qualifies for **MEDICARE** benefits because of end stage renal disease or could have qualified for Medicare benefits if he had applied at the earliest time possible because of end stage renal disease from the fourth through the twenty-seventh month on dialysis. After thirty (30) continuous months on dialysis, **MEDICARE** will become primary and this **PLAN** secondary. In the case of a kidney transplant, this **PLAN** will be primary to **MEDICARE** for the first twenty-seven (27) months of **MEDICARE** entitlement. For the first twenty-seven (27) months of **MEDICARE** entitlement, all bills should be filed initially with this **PLAN**; after twenty-seven (27) months of **MEDICARE** entitlement, file all bills initially to **MEDICARE**.

It is the **COVERED PERSON'S** responsibility to apply for the **MEDICARE** benefits that are available to him and his dependents. If **MEDICARE** coverage is primary and the **COVERED PERSON** has not applied for coverage under **MEDICARE**, this **PLAN** will calculate the benefits it provides as if he were enrolled in **MEDICARE**, regardless of whether or not he has applied. If he is an active **COVERED EMPLOYEE** over age 65 and declines coverage under this **PLAN**, a written notice of declination must be submitted to the **PLAN ADMINISTRATOR**.

The PLAN will provide notice of creditable coverage in accordance with the Medicare Modernization Act and Medicare Part D.

Coordination Of Benefits

The **COORDINATION OF BENEFITS** provision is intended to prevent the payment of benefits which exceeds expenses. It applies when the **COVERED PERSON** is covered by more than one plan. When two or more coverages exist, one plan normally pays its benefits in full and the other plan or plans pay a reduced benefit. This **PLAN** will always consider either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount actually paid by this **PLAN** will be charged against this **PLAN'S** maximums.

The **COORDINATION OF BENEFITS** provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this **PLAN** to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments. All benefits contained in this Plan Document and Summary Plan Description are subject to these provisions.

- **Definitions**

The term "Plan" as used herein will mean any plan providing benefits or services for or by reason of medical treatment, and such benefits or services are provided by:

1. All group plans or any other arrangement for coverage for a **COVERED PERSON** in a group whether on an insured, uninsured or self-funded basis, including but not limited to:
   a. **HOSPITAL** indemnity benefits; and
   b. **HOSPITAL** reimbursement-type plans which permit the **COVERED PERSON** to elect indemnity at the time of claims;
   c. Franchise insurance;
   d. Blanket insurance coverage.
2. **HOSPITAL** or medical service organizations on a group basis, group practice and other group pre-payment plans; or
3. **HOSPITAL** or medical service organizations on an individual basis having a provision similar in effect to this provision; or
4. A Licensed Health Maintenance Organization (HMO); or
5. Any coverage for students which is sponsored by or provided through a school or other **EDUCATIONAL INSTITUTION**; or
6. Any coverage under a governmental program, **MEDICARE** and any coverage required or provided by any statute; or
7. Group automobile insurance; or
8. Individual automobile insurance coverage on an automobile leased or owned by the **EMPLOYER**; or
9. Individual automobile insurance coverage inclusive of Personal Injury Protection based on the principles of No-Fault, Med pay, uninsured and underinsured; or
10. Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans; or
11. Home-owners insurance coverage; or
12. Third party liability coverage; or
13. Dental coverage which is part of a medical plan; or
14. All individual plans.

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

The term "Allowable Expenses" shall mean the **USUAL AND CUSTOMARY** charge for any Medically **NECESSARY**, **REASONABLE**, eligible item of expense, at least a portion of which is covered under this **PLAN**. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO **PROVIDER** has agreed to accept as payment in full. Further, when an HMO is primary and the **COVERED PERSON** does not use an HMO **PROVIDER**, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the **COVERED PERSON** used the services of an HMO **PROVIDER**.

The term "Claim Determination Period" means a **CALENDAR YEAR** or that portion of a **CALENDAR YEAR** during which the **COVERED PERSON** for whom claim is made has been covered under this **PLAN**.

If both the husband and wife are eligible for coverage under this **PLAN**, **COORDINATION OF BENEFITS** will be administered in the normal **COORDINATION OF BENEFITS** fashion, allowing charges under both individual's coverage. However, the individual shall be limited to one annual maximum as shown in the SCHEDULE OF BENEFITS.

- **Excess Insurance**

If at the time of **INJURY**, **ILLNESS**, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this **PLAN** shall apply only as an excess over such other sources of Coverage. The **PLAN**'s benefits will be excess to, whenever possible:

a) any primary payer besides the **PLAN**;
b) any first party insurance through medical payment coverage, personal **INJURY** protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company or
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

- **Vehicle Limitation**

When medical payments are available under any vehicle insurance, the **PLAN** may pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This **PLAN** shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

- **Coordination Procedures**

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

1. Benefits either as an insured person, covered person, Qualifying Beneficiary or, as a dependent under any other plan which has no provision similar in effect to this provision.
2. **DEPENDENT** benefits under this **PLAN**, who are also eligible for benefits:
   a. as an insured person or covered person under any other plan, or
   b. as a dependent covered under another group plan.
3. **COVERED PERSON** benefits under this **PLAN**, who are also eligible for benefits as an insured person or covered person under any other plan and has been covered continuously for a longer period of time under such other plan. In cases where there are benefits available either as a retiree or laid-off employee, the plan which covers the person as a retiree or laid-off employee shall pay second.
4. **COVERED DEPENDENT** benefits under this **PLAN**, who elect membership in a Health Maintenance Organization (HMO) as an employee of another employer. Benefits under this **PLAN** are limited to co-payment and/or **DEDUCTIBLES** not covered under the HMO, and to eligible expenses that are specifically excluded under the HMO. There will be no coverage under this **PLAN** for any item not covered by the HMO because a **DEPENDENT** chose not to avail himself to the HMO participating provider.
5. Coverage as a covered dependent under another group plan on a non-contributory basis as an employee of another employer who does not choose to enroll for such coverage, benefits will be coordinated as though he had enrolled. If the employer of a **COVERED DEPENDENT** pays the full premium or provides money for the payment of the full premium of another plan, such plan shall be considered a group plan for the purposes of this section.
6. Benefits under mandated no-fault automobile insurance whether or not enrolled or covered. Benefits will be coordinated as though covered.
7. Benefits under homeowner's coverage or third party liability coverage.

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

- **Order of Benefit Determination**

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

1. If another plan contains no provision for **COORDINATION OF BENEFITS**, then it pays before all other plans.

2. The plan which covers the **COVERED PERSON** as an employee named insured (except in cases of retirees or laid-off employees, see 5 below) or Qualified Beneficiary pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the **COVERED PERSON** as a dependent.

3. If the **COVERED PERSON** is a **DEPENDENT CHILD**, the plan of the parent whose birthday occurs earliest in the **CALENDAR YEAR** shall pay first. If both parents have the same birthday the benefits of the plan which covered the parent the longest are determined first. However, the following exceptions apply in a case of a person for whom claim is made as a **DEPENDENT CHILD**:

    a. when the parents are separated or divorced and the parent with the custody of the **CHILD** has not remarried, the benefits of a plan which covered the **CHILD** as a **DEPENDENT** of the parent with custody of the **CHILD** will be determined before the benefits of a plan which covers the **CHILD** as a **DEPENDENT** of the parent without custody; or

    b. when the parents are divorced and the parent with the custody of the **CHILD** has remarried, the benefits of a plan which covers the **CHILD** as a **DEPENDENT** of the parent with the custody shall be determined before the benefits of a plan which covers that **CHILD** as a **DEPENDENT** of the step-parent, and the benefits of a plan which covers that **CHILD** as a **DEPENDENT** of the step-parent will be determined before the benefits of a plan which covers that **CHILD** as a **DEPENDENT** of the parent without custody; or

    c. when a court decree fixes responsibility for health care expense on a specific parent, such decree shall be honored before any other section or subsection of this provision.

    d. if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the **CHILD**, the plans covering the **CHILD** shall follow the order of benefit determination in Rule #3.

4. If the other plan does not have the rule based on the birthdays of the parent, but instead has a rule based upon the gender of the parent, the plans do not agree on order of benefit determination. In this case, the rule based upon the gender of the parent will determine the order of benefits.

5. In cases where there are benefits available either as a retiree or laid-off employee, the plan which covers the person as a retiree or laid-off employee shall pay second.

6. If the order set out in 1, 2, 3, 4, or 5 above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will consider first.

7. In cases where benefits are available through school insurance, automobile insurance, homeowner's insurance and/or any first or third party liability insurance, this **PLAN** shall pay second.

- **Release of Information**

The **PLAN ADMINISTRATOR**, or its designee, has the right:

1. To obtain or share information with an insurance company or any other organization regarding **COORDINATION OF BENEFITS** without the **COVERED PERSON'S** consent.

2. To require that the **COVERED PERSON** provide the **PLAN ADMINISTRATOR**, or its designee, with information on such other plans so that this provision may be implemented.

3. To pay over the amount due under this **PLAN** to an insurer or any other organization if this is necessary, in the **PLAN ADMINISTRATOR'S**, or its designee's, opinion to satisfy the terms of this provision.

- **Facility of Payment**

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

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

- **Right of Recovery**

In accordance with the Right of Recovery section, whenever payments have been made by this **PLAN** with respect to **ALLOWABLE EXPENSES** in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the **PLAN** shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this **PLAN** shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the **PLAN** determines are responsible for payment of such **ALLOWABLE EXPENSES**, and any future benefits payable to the **COVERED PERSON** or his or her **DEPENDENTS**.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Introduction

Applicable Law. This **PLAN** has been established and operates under the guidelines of the State of Vermont and Federal Laws. The **PLAN** is funded with employee and employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority. The **PLAN ADMINISTRATOR** shall have sole, full and final discretionary authority to interpret all **PLAN** provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the **PLAN** and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan **COVERED PERSONS** rights; and to determine all questions of fact and law arising under the **PLAN**.

Payment Condition

1. The **PLAN**, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an **INJURY**, **ILLNESS**, Disease or disability is caused in whole or in part by, or results from the acts or omissions of **COVERED PERSONs**, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "**COVERED PERSON**(s)") or a third party, where any party besides the **PLAN** may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. **COVERED PERSON**(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the **PLAN'S** conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the **PLAN'S** conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the **PLAN** or the **PLAN'S** assignee. By accepting benefits the **COVERED PERSON**(s) agrees the **PLAN** shall have an equitable lien on any funds received by the **COVERED PERSON**(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The **COVERED PERSON**(s) agrees to include the **PLAN'S** name as a co-payee on any and all settlement drafts.

3. In the event a **COVERED PERSON**(s) settles, recovers, or is reimbursed by any Coverage, the **COVERED PERSON**(s) agrees to reimburse the **PLAN** for all benefits paid or that will be paid by the **PLAN** on behalf of the **COVERED PERSON**(s). If the **COVERED PERSON**(s) fails to reimburse the **PLAN** out of any judgment or settlement received, the **COVERED PERSON**(s) will be responsible for any and all expenses (fees and costs) associated with the **PLAN'S** attempt to recover such money.

4. If there is more than one party responsible for charges paid by the **PLAN**, or may be responsible for charges paid by the **PLAN**, the **PLAN** will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the **COVERED PERSON**(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this **PLAN**, the **COVERED PERSON**(s) agrees to assign to the **PLAN** the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the **COVERED PERSON**(s) is entitled, regardless of how classified or characterized, at the **PLAN'S** discretion.

2. If a **COVERED PERSON**(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the **PLAN** to any claim, which any **COVERED PERSON**(s) may have against any Coverage and/or party causing the **ILLNESS** or **INJURY** to the extent of such conditional payment by the **PLAN** plus reasonable costs of collection.

3. The **PLAN** may, at its discretion, in its own name or in the name of the **COVERED PERSON**(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the **PLAN**.

4. If the **COVERED PERSON**(s) fails to file a claim or pursue damages against:

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

    the **COVERED PERSON**(s) authorizes the **PLAN** to pursue, sue, compromise and/or settle any such claims in the **COVERED PERSON**(s)' and/or the **PLAN'S** name and agrees to fully cooperate with the **PLAN** in the prosecution of any such claims. The **COVERED PERSON**(s) assigns all rights to the **PLAN** or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The **PLAN** shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the **COVERED PERSON**(s) is fully compensated by his/her recovery from all sources. The **PLAN** shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the **PLAN'S** equitable lien and right to reimbursement. The obligation to reimburse the **PLAN** in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the **COVERED PERSON**(s)' recovery is less than the benefits paid, then the **PLAN** is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the **PLAN'S** recovery without the prior, expressed written consent of the **PLAN**.

3. The **PLAN'S** right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the **COVERED PERSON**(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating **PLAN'S** recovery will not be applicable to the **PLAN** and will not reduce the **PLAN'S** reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the **PLAN** and signed by the **COVERED PERSON**(s).

5. This provision shall not limit any other remedies of the **PLAN** provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable **ILLNESS**, **INJURY**, Disease or disability.

Excess Insurance

If at the time of **INJURY**, **ILLNESS**, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this **PLAN** shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the PLAN'S Coordination of Benefits section.

The **PLAN'S** benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the **PLAN**, funds recovered by the **COVERED PERSON**(s), and funds held in trust over which the **PLAN** has an equitable lien exist separately from the property and estate of the **COVERED PERSON**(s), such that the death of the **COVERED PERSON**(s), or filing of bankruptcy by the **COVERED PERSON**(s), will not affect the **PLAN'S** equitable lien, the funds over which the **PLAN** has a lien, or the **PLAN'S** right to subrogation and reimbursement.

Wrongful Death

In the event that the **COVERED PERSON**(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the **PLAN'S** subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these **PLAN** rights and terms by which benefits are paid on behalf of the **COVERED PERSON**(s) and all others that benefit from such payment.

Obligations

1. It is the **COVERED PERSON**(s)' obligation at all times, both prior to and after payment of medical benefits by the **PLAN**:
    a. To cooperate with the **PLAN**, or any representatives of the **PLAN**, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the **PLAN'S** rights;
    b. To provide the **PLAN** with pertinent information regarding the **ILLNESS**, Disease, disability, or **INJURY**, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the **PLAN** may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. To do nothing to prejudice the **PLAN'S** rights of subrogation and reimbursement;
    e. To promptly reimburse the **PLAN** when a recovery through settlement, judgment, award or other payment is received; and
    f. To not settle or release, without the prior consent of the **PLAN**, any claim to the extent that the **COVERED PERSON** may have against any responsible party or Coverage.

2. If the **COVERED PERSON**(s) and/or his or her attorney fails to reimburse the **PLAN** for all benefits paid or to be paid, as a result of said **INJURY** or condition, out of any proceeds, judgment or settlement received, the **COVERED PERSON**(s) will be responsible for any and all expenses (whether fees or costs) associated with the **PLAN'S** attempt to recover such money from the **COVERED PERSON**(s).

3. The PLAN'S rights to reimbursement and/or subrogation are in no way dependent upon the **COVERED PERSON**(s)' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the **COVERED PERSON** and/or his/her attorney fails to comply with any of the requirements of the **PLAN**, the **PLAN** has the right, in addition to any other lawful means of recovery, to deduct the value of the **COVERED PERSON's** amount owed to the **PLAN**. To do this, the **PLAN** may refuse payment of any future medical benefits and any funds or payments due under this **PLAN** on behalf of the **COVERED PERSON**(s) in an amount equivalent to any outstanding amounts owed by the **COVERED PERSON** to the **PLAN**.

Minor Status

1. In the event the **COVERED PERSON**(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the **PLAN** to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the **PLAN** shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the **PLAN'S** subrogation and reimbursement rights. The Plan Administrator may amend the **PLAN** at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and **PLAN**. The section shall be fully severable. The **PLAN** shall be construed and enforced as if such invalid or illegal sections had never been inserted in the **PLAN**.

- **Fiduciary Duties and Rights**

The **PLAN ADMINISTRATOR** shall have sole, full and final discretionary authority to interpret all **PLAN** provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the **PLAN** and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a **COVERED PERSON'S** rights; and to determine all questions of fact and law arising under the **PLAN**.

The **PLAN ADMINISTRATOR** may delegate certain of its fiduciary responsibilities under this **PLAN** to persons who are not named fiduciaries of this **PLAN**. If the **PLAN ADMINISTRATOR** delegates its fiduciary responsibilities to another person, the delegation shall be made in writing by the **PLAN ADMINISTRATOR** and a copy of the delegation will be kept with the records of this **PLAN**.

Each fiduciary is solely responsible for its own acts or omissions. Except to the extent required by the State of Vermont and Federal Laws, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibilities by another fiduciary with respect to this **PLAN** unless (a) it participates knowingly in such breach, knowingly undertakes to conceal such breach or has actual knowledge of such breach and fails to take reasonable action to remedy such a breach or (b) through its negligence in performing its specific fiduciary responsibilities which gave rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary is liable for breach of fiduciary duty before it became a fiduciary and nothing in this **PLAN** shall relieve any person from liability for his or her own misconduct or fraud.

- **Plan Administrator Duties**

The duties of the **PLAN ADMINISTRATOR** include the following:

1. To administer the **PLAN** in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the **PLAN**;
3. To interpret the **PLAN**, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a **COVERED PERSON**'s rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the plan documents and all other records pertaining to the **PLAN**;
8. To appoint and supervise a third party administrator (or **PLAN SUPERVISOR**) to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether a medical child support order is a **QMCSO**;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the **PLAN**'s administration.

- **Plan Administrator And Plan Administration**

As **PLAN ADMINISTRATOR**, the **EMPLOYER** will comply with all requirements. The **PLAN ADMINISTRATOR** may also make rulings, interpret this **PLAN**, describe procedures, gather needed information, receive and review financial information regarding this **PLAN**, employ or appoint individuals to assist in any administrative function and generally do all things needed to administer this **PLAN**.

The **PLAN ADMINISTRATOR** has all powers and authority needed to enable it to carry out its duties under this **PLAN**, including by way of illustration and not limitation the powers and authority to make rules with respect to this **PLAN** not inconsistent with the terms of this **PLAN** and to determine, consistent with those rules, all the status and rights of **COVERED PERSONS**, beneficiaries and other persons.

Failure by this **PLAN** or **PLAN ADMINISTRATOR** to insist upon compliance with any provision of this **PLAN** at any time or under any set of circumstances shall not operate to waive or modify any provision of this **PLAN** or in any manner render it unenforceable as to any other situation or circumstance, whether the situation or circumstance is or is not the same. No waiver of any term or condition of this **PLAN** shall be valid or of any force or effect unless contained in a written memorandum expressing the waiver and signed by a person authorized by the **PLAN ADMINISTRATOR** to sign the waiver.

This **PLAN** shall be interpreted by the **PLAN ADMINISTRATOR** under applicable laws of the State of Vermont and/or federal laws.