

CITY OF GOLDSBORO
MEDICAL CARE PLAN
SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

REVISED SEPTEMBER 1, 2007

TABLE OF CONTENTS

	INTRODUCTION	i
ARTICLE I	PURPOSE OF PLAN	1
1.1	Rights and Protections	1
1.2	Statement of ERISA Rights	1
ARTICLE II	CONSTRUCTION.....	2
ARTICLE III	COMPREHENSIVE MEDICAL BENEFITS.....	3
3.1	Schedule of Medical Care Benefits	3
3.2	The Deductible	8
3.3	Copayment Percentages.....	8
3.4	Maximum Out-of-Pocket Limit.....	8
3.5	Covered Medical Expenses	8
3.6	Exclusions and Limitations	14
ARTICLE IV	PARTICIPATION	17
4.1	Eligibility for Benefits	17
4.2	Enrollment	17
4.3	Special Enrollment Procedure	18
4.4	Open Enrollment Period	19
4.5	Coverage Changes Due to a Life Event	19
4.6	Enrollment Pursuant to Qualified Medical Child Support Orders	20
4.7	Pre-Existing Conditions	20
4.8	Termination of Participation.....	22
4.9	Continuation of Coverage (COBRA).....	23
4.10	Integration with Medicare.....	28
ARTICLE V	PRECERTIFICATION OF SERVICES	28
5.1	Scope of Precertification Review	28
5.2	Precertification Review Procedures	29
5.3	Failure to Follow Precertification Review Procedures.....	30
5.4	Denial by Utilization Review Service.....	30
5.5	Precertification and Preauthorization	30
ARTICLE VI	COORDINATION OF BENEFITS	30
6.1	Purpose	30
6.2	Primary and Secondary Plans	30
6.3	Eligible Plans.....	31
6.4	Ineligible Plans.....	31
6.5	Order of Benefit Determination.....	31
6.6	Payment of Benefits	32
6.7	Right to Receive and Release Necessary Information.....	32

TABLE OF CONTENTS

ARTICLE VII	ADMINISTRATION.....	32
7.1	Appointment of Committee.....	32
7.2	Claims Processing Procedures.....	32
7.3	HIPAA Privacy.....	39
7.4	HIPAA Security.....	42
7.5	Records and Reports.....	43
7.6	Other Benefit Committee Powers and Duties.....	43
7.7	Rules and Decisions.....	44
7.8	Benefit Committee Procedures.....	44
7.9	Authorization of Claims Processing.....	44
7.10	Application and Forms for Benefits.....	44
7.11	Indemnification of the Benefit Committee.....	44
7.12	Claims Administrator.....	44
ARTICLE VIII	MISCELLANEOUS.....	45
8.1	Non Guarantee of Employment.....	45
8.2	No Rights to Assets of Employer or Plan Assets.....	45
8.3	Non-Alienation of Benefits.....	45
8.4	Right of Reimbursement.....	45
8.5	Subrogation.....	46
8.6	Medicaid Assignment of Rights and Reimbursement.....	46
8.7	Recovery of Overpayment.....	46
ARTICLE IX	AMENDMENTS AND ACTION BY THE EMPLOYER.....	47
9.1	Amendments.....	47
9.2	Action by the Employer.....	47
ARTICLE X	SUCCESSOR EMPLOYER AND MERGER OR CONSOLIDATION OF PLANS.....	47
10.1	Successor Employer.....	47
ARTICLE XI	PLAN TERMINATION.....	47
11.1	Right to Terminate.....	47
11.2	Liquidation of the Plan Assets.....	47
ARTICLE XII	DEFINITIONS.....	48
ARTICLE XIII	GENERAL PLAN INFORMATION.....	59
ARTICLE XIV	APPLICATION OF STATE LAW.....	61

INTRODUCTION

The information contained in this document is a description of City of Goldsboro (the Plan) Employee Benefit Plan and defines how this Plan works. If you do not understand anything in this document, your Plan Administrator will be able to clarify any of your questions.

City of Goldsboro fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

This document, in English, provides details of your Plan rights and benefits under City of Goldsboro Medical Care Plan. If you have difficulty understanding any part of this document, contact Veloris Allen, the Plan Administrator, at 214 North Center Street, Goldsboro, NC 27533. Office hours are from 8 a.m. to 5 p.m. Monday through Friday. You may also call the Plan Administrator's office at 1-919-580-4372 for assistance.

If you participate in a Health Flexible Savings Account (HFSA) or Dependent Care Account, you should receive a separate document describing these benefits.

ARTICLE I

PURPOSE OF PLAN

The Employer hereby establishes this self-funded Plan under the Internal Revenue Code and Employee Retirement Income Security Act (ERISA) of 1974, as amended, to provide the medical care benefits as set forth herein for the Participants.

1.1 **Rights and Protections.** As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974. ERISA provides that all Plan Participants shall be entitled to:

- A. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance Contracts and collective bargaining agreements filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- B. Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and updated summary plan descriptions and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- C. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

1.2 **Statement of ERISA Rights.** In addition to creating rights for Plan Participants, ERISA imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied, in whole or in part, you have the right to know why this has been done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the status of a Qualified Medical Child Support Order, you may file in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication's hot line of the Employee Benefits Security Administration.

ARTICLE II

CONSTRUCTION

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender. The words "hereof", "herein", "hereunder", and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or section.

ARTICLE III

COMPREHENSIVE MEDICAL BENEFITS

3.1 Schedule of Medical Care Benefits.

Preferred Provider Organization (PPO)

This Plan utilizes Atlantic Integrated Health (AIH) and Duke University Hospital and from time to time other networks depending on availability of coverage and market served. The Preferred Provider Organization has contracted with health care Providers for services at a reduced fee. Each time a Participant needs Medical Care, he can choose to receive care from an In-Network or Out-of-Network Provider. As set forth in this Schedule of Benefits, there are benefit incentives for participating Employees and their Dependents who utilize PPO Providers. A directory of the Providers in the PPO network is furnished by the Plan Administrator as a separate document without charge or accessible online if available.

If certain covered Providers, such as Ambulance services, Home Health Care Agencies, Hospice Care Agencies or oral surgeons, provide Covered Services to a Participant that are not available through the PPO network, those Covered Services will be considered at the PPO level.

If a Participant uses a network facility for Inpatient/outpatient Surgery, but the network facility uses a non-network Provider for Anesthesia, the interpretation of laboratory tests and X-rays, and other Medically Necessary services, the Plan will consider benefits at the PPO level.

If network Providers are not accessible on a temporary basis (e.g. students, on vacation or out of the country), the Plan will consider benefits for Providers not in the PPO network at the PPO level. All Covered Services are subject to any applicable Deductible, Out-of-Pocket Maximums and the Usual, Customary and Reasonable Charge.

Schedule of Medical Care Benefits		
	PPO	Non-PPO
Maximum Lifetime Benefit Amount Up to \$1,000,000 may be restored each January 1; Drug/Alcohol Abuse maximums may not be restored; no restoration of benefits is available for Employees or Dependents that are terminated	\$2,000,000	\$2,000,000
NOTE: Amounts incurred to satisfy Non-PPO Maximum Lifetime Benefit Amount do apply to satisfy PPO Maximum Lifetime Benefit Amount and vice versa		
Deductibles		
Individual per Calendar Year	\$300	\$300
Family per Calendar Year	\$600	\$600
NOTE: Amounts incurred to satisfy Non-PPO Deductible do apply to satisfy PPO Deductible and vice versa.		

	PPO	Non-PPO
Maximum Out-of-Pocket Limit (includes Deductible)		
Individual per Calendar Year	\$2,000	\$3,000
Family per Calendar Year	\$4,000	\$6,000
The following charges do not apply toward the Out-of-Pocket maximum. Any penalty amounts for non-precertification, any amounts over the Usual, Customary and Reasonable Charge, any applicable Copayments and per admission deductible.		
NOTE: Amounts incurred to satisfy Non-PPO Out-of-Pocket amounts do apply to satisfy PPO Out-of-Pocket amounts and vice versa.		

Covered Services	PPO	NON-PPO
Copayment Percentages after the Deductible has been met (unless otherwise listed below)	80%-Plan 20%-Participant	70%-Plan 30%-Participant
Allergy Testing, Injections and Vials/Medication	80%*	70%*
Ambulance Emergency transport to nearest Hospital qualified to provide treatment	80%*	70%*
Birthing Center	80%*	70%*
Chiropractor Limited to twenty-five (25) visits per Calendar Year including all related expenses, PPO and Non-PPO combined	80%*	70%* \$25 maximum covered per visit (does not include X-rays)
Diagnostic X-Ray and Laboratory	80%*	70%*
Emergency Room and Emergency Room Physician Copay is waived if admitted	80%* after \$100 per visit copay	70%* after \$100 per visit copay
Extended Care Facility Limited to 100 days per twelve (12) consecutive months, PPO and Non-PPO combined	80%*	70%*
Home Health Care	80%*	70%*
Hospice	80%*	70%*
Inpatient Consultations	80%*	70%*
Inpatient Drug/Alcohol Abuse Thirty (30) days per Calendar Year, PPO and Non-PPO combined; \$25,000 lifetime maximum for all Inpatient and all outpatient services, PPO and Non-PPO combined	80%*	70%*
Inpatient Hospital Stays Unlimited days per Calendar Year; Semi-Private, ICU and CCU room rate allowances; All admissions are subject to Precertification procedures	80%*	70%*
Inpatient Mental/Nervous Disorders Thirty (30) days per Calendar Year, PPO and Non-PPO combined	80%*	70%*
Inpatient Surgery	80%*	70%*
Inpatient Visits	80%*	70%*
Non Experimental Transplant	80%*	70%*
Non-Precertification Penalty	Benefits for Hospital expenses are reduced to 60%*	
Office Diagnostics	80%*	70%*
Office Surgery	80%*	70%*
Office Visit	80%*	70%*

*Subject to the Calendar Year Deductible

Covered Services	PPO	NON-PPO
Temporomandibular Joint Disorder (TMJ) Lifetime maximum \$1,500 for diagnosis and treatment, PPO and Non-PPO combined	80%*	70%*
Therapeutic/Medical Equipment Repair/Replacement is subject to Medical Necessity and/or age of the equipment	80%*	70%*
Therapy Services Cardiac Rehabilitation Chemotherapy Kidney Dialysis Occupational Treatment necessary to promote restoration of the patient's ability to perform ordinary and fundamental tasks of daily living Physical Radiation Respiratory Speech Restorative/rehabilitative therapy for situations where normal speech was lost due to illness/Surgery; If due to congenital anomaly the patient must have had corrective Surgery	80%* 80%* 80%* 80%* 80%* 80%* 80%* 80%*	70%* 70%* 70%* 70%* 70%* 70%* 70%* 70%*
Urgent Care Facility	80%*	70%*
Wellness Benefit Well Adult Care \$250 maximum per Calendar Year; PPO and Non-PPO combined; after \$250 is exhausted, charges are not covered; includes related services and adult immunizations Well Baby/Child Care \$250 maximum per Calendar Year; PPO and Non-PPO combined; after \$250 is exhausted, charges are not covered; includes related services and baby/Child immunizations	100%, no Deductible 100%, no Deductible	100%, no Deductible 100%, no Deductible
NOTE: The per visit copays and per admission deductibles are deducted even if the Out-of-Pocket is met.		

***Subject to the Calendar Year Deductible**

3.2 **The Deductible.** The designated amount of Covered Medical Expenses paid by the Participant each Calendar Year before such Covered Medical Expenses then become subject to payment as Plan benefits. Specific Deductible amounts are set forth in the Schedule of Benefits.

The Deductible amount designated "individual" applies to each individual Participant. If the combined Deductibles of a participating Employee and his participating Dependent(s) equals or exceeds the Deductible designated "family," the individual Deductibles of each such participating Employee and his participating Dependent(s) shall be deemed satisfied.

Provided, however, with respect to Covered Medical Expenses, if two (2) or more family members sustain Injuries in a single accident, only one (1) "individual" Deductible amount shall be required for all Covered Medical Expenses related to the treatment of such Injuries for all family members.

Any Covered Medical Expenses applied against a Participant's individual Deductible in the last three (3) months of a Calendar Year shall also reduce the individual Participant's Deductible for the next succeeding Calendar Year.

3.3 **Co-payment Percentages.** After the Participant's applicable Deductible has been met for a Calendar Year, the Plan shall pay the percentage of any Covered Medical Expenses listed in the Schedule of Benefits of the Usual, Customary and Reasonable Charges. The Participant is responsible for the remaining percentage up to the maximum Out-of-Pocket Limit listed in the Schedule of Benefits.

3.4 **Maximum Out-of-Pocket Limit.** When, in a Calendar Year, a Participant has incurred medical expenses in the amount equal to the Out-of-Pocket Limit for Covered Medical Expenses not payable under this Plan due to percentages less than 100% and the Deductible, the Plan shall then pay 100% of Covered Medical Expenses incurred beyond the maximum Out-of-Pocket Limit for the remainder of that Calendar Year.

The family maximum Out-of-Pocket Limit is listed in the Schedule of Benefits. Items excluded from this provision are also listed in the Schedule of Benefits.

3.5 **Covered Medical Expenses.**

A. Inpatient Hospital Expenses:**

1. Room and Board Charges (average semiprivate room rate allowance, private room rate difference is eligible only when the Hospital is an all private facility and when Medically Necessary);
2. Operating, delivery and treatment rooms and equipment;
3. Intensive care, cardiac care or other similar necessary accommodations;
4. Private duty nursing by a Registered Graduate Nurse other than a nurse who is a member of the Participant's family or his Spouse's family; and
5. Ancillary Charges.

** **The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of**

stay not in excess of said periods. Hospital lengths of stay exceeding these time periods require Precertification.

- B. Extended Care Facility charges provided:
1. Confinement must be for the same or related illness or Injury that caused the preceding Hospital Confinement;
 2. A Physician recommends confinement for convalescence from the condition or related condition which caused the Hospital confinement;
 3. The Participant is under the continuous care of a Physician during the entire period of confinement;
 4. The Participant commences his stay in the Extended Care Facility within fourteen (14) days following discharge from the Hospital.

Eligible Extended Care Facility charges shall be:

- a. Room and Board Charges; and
- b. Ancillary Charges, not including any charges for professional services ordered by a Physician and furnished by the facility for Inpatient care.

- C. Outpatient Hospital Expenses:

1. Diagnostic tests and X-rays;
2. Pre-operative, operative and post-operative services;
3. Ancillary Charges;
4. Emergency room in cases of Medical Emergency; and
5. Emergency room in cases other than Medical Emergencies.

- D. Surgical Expenses:

Surgery includes the Medically Necessary preoperative and post operative care, when performed by a Physician. Services are subject to Precertification review procedures as detailed in Article V. If two (2) or more operations or procedures are performed on the same day, on the same patient, by the same Physician, benefits are described in the Schedule of Benefits and are subject to the Usual, Customary and Reasonable Charges, or other negotiated rate, for the first procedure, and 50% of Usual, Customary and Reasonable Charges, or other negotiated rate, for any additional procedures.

Surgical Assistance Service. Medically Necessary service of one (1) Physician who actively assists the operating surgeon when a covered Surgery is performed in a Hospital, and when such surgical assistance service is not available by an intern, resident or house Physician. The Plan provides benefits equal to 20% of the allowance for the Surgery, not to exceed the Physician's actual charge.

Anesthesia Service. Service rendered by a Physician or a certified registered nurse anesthetist, other than by the attending surgeon or his assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration. Additional benefits are not provided for preoperative Anesthesia consultation.

Outpatient Surgery. A Participant receiving services in a Hospital, but not admitted as a registered bed-patient, is entitled to a benefit equal to the Hospital's regular charges for the services furnished him, but only for the following:

1. Hospital care for accidental Injury including X-ray and lab services provided on the same day as treatment;
 2. Use of the Hospital's facilities and equipment for Surgery, including X-ray and lab services provided on the same day as Surgery;
 3. Use of the Hospital's facilities and equipment for radiation therapy, inhalation therapy and physical therapy;
 4. Benefits will be provided for the initial treatment of a Medical Emergency;
 5. Charges incurred for a second and/or third Surgical Opinion;
 6. Elective abortions, benefits are covered for the Employee and Spouse only;
 7. Sterilization procedures for participating Employees, Retired Employees and participating Spouses, but not including Surgery for the reversal of sterilization;
 8. Oral Surgery:
 - a. Accidental Injury of external violent means to sound natural teeth for treatment within twelve (12) months of the accident; and
 - b. Medically Necessary Hospital expenses when admitted to the Hospital for dental treatment.
 - Not covered:
 - a. Removal of wisdom teeth;
 - b. Services performed on or to gingival or alveolar process;
 - c. Periodontal Surgery; and
 - d. Other procedures involving teeth in their bone or supporting tissue.
- E. Professional Services:
1. Physician services for performing or assisting in the performance of Surgery or an obstetrical procedure, home, office and Hospital visits and other Medical Care and treatment;
 2. Charges for an elective second Surgical Opinion or third Surgical Opinion to either confirm or deny proposed Surgery:
 - a. Second opinions are not required;
 - b. Physician doing second opinion cannot be the surgeon;
 - c. The second opinion must be done before the Surgery;
 - d. The second opinion is not covered if the second opinion is for a non-covered Surgery;
 - e. The second opinion is not covered if it is required by a Hospital; or
 - f. The second opinion is not covered if the Surgery does not require the use of a Hospital's major operation room or that of a qualified surgical center or was not performed under general anesthesia.
 3. Anesthesia and its administration;
 4. Diagnostic X-ray or laboratory examinations and their interpretation;
 5. Outpatient pre-admission testing;
 6. Maternity Benefits:
 - a. Expenses for participating Employees or their participating Spouses;
 - b. Expenses are covered on the same basis as Sickness;
 - c. Birthing Center services or Nurse-Midwives/Practitioners for Medically Necessary services in connection with delivery of a Child or Children provided in state certified Birthing Centers. The Nurse-Midwife/Practitioner must be licensed for the nature of services provided by the state he or she is operating in;

- d. Inpatient charges for a newborn baby for routine nursery room and board and for routine professional services required for the newborn. Routine nursery benefits are limited to the period of the mother's confinement and will be considered for payment as an eligible expense under the newborn Participant when added to the Plan as described under the heading "Participation."

NOTE: If the newborn is not a "well baby", all eligible expenses will be considered under the newborn Participant when added to the Plan as described under the heading "Participation."

7. Chiropractic medical care, treatment, and X-rays;
 8. Therapeutic treatment as described in the Schedule of Benefits:
- F. Office visits and audiological testing for the diagnosis of hearing loss;
- G. Mental/Nervous Disorders and Drug/Alcohol Abuse Treatment:

The Plan will pay eligible expenses for Inpatient and outpatient treatment of mental/nervous disorders and drug/alcohol abuse as detailed in the Schedule of Benefits. The maximum amount payable on account of all Covered Medical Expenses incurred with respect to any one (1) Participant is listed in the Schedule of Benefits.

The provisions concerning mental/nervous disorders and drug/alcohol abuse apply only to services resulting from diagnosis or recommendation by a Physician and only to expenses to the extent that they are for treatment recognized by the medical profession as appropriate methods of treatment in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. Expenses incurred for treatment of mental/nervous disorders and drug/alcohol abuse will be considered as Covered Medical Expenses only as provided above.

Psychologists that:

1. Have a doctorate practice degree in psychology and at least two (2) years clinical experience in a recognized health setting; or
2. Meets the standards of the national register of health services provided in psychology and is licensed or certified in the state; or
3. Other Providers of service certified to provide mental health services including master of social worker.

H. Home Health Care Expenses:

1. Following a Hospital confinement for same/related condition or in lieu of a Hospital confinement;
 2. Intermittent services of an RN or LPN;
 3. Intermittent home health aide services;
 4. Physical, speech and occupational therapy;
 5. Each visit by a member of a home health care team will be considered as one (1) visit;
 6. Four (4) hours of home health care or four (4) hours of home health aide services will be considered as one (1) visit.
- Not covered: meal preparation, personal comfort items, housekeeping, social service workers.

- I. Hospice benefits shall be as follows:
- Period of Bereavement. A period beginning on the date of the death of the terminally ill or hospice patient and ending six (6) months after.
- Terminally Ill Patient. A Participant with a life expectancy of six (6) months or less as certified in writing by the attending Physician.
1. In order to be eligible for this hospice benefit, the terminally ill patient must be confined in a Hospital in connection with the terminal illness immediately prior to participating in a hospice program. The hospice benefit pays Usual, Customary and Reasonable Charges, provided such charges are incurred during the period of participation in the Plan or a Period of Bereavement. Covered Medical Expenses must be incurred for services provided for the family unit of the Participant under the Hospice program of care that are rendered by a Hospice Care Agency or other facility on behalf of the Hospice Care Agency.
 2. Covered Hospice Expenses include:
 - a. Inpatient hospice care;
 - b. Physicians' services;
 - c. Home Health Care services, including:
 1. Part-time nursing care rendered in the Participant's home;
 2. Physician's visits to the Participant's home;
 3. Physical therapy provided in the Participant's home;
 4. The use of medical equipment;
 5. The rental of wheelchairs and Hospital type beds;
 6. Emotional support services of a Physician;
 7. Drugs and medication;
 8. Homemaker services;
 9. Nutritional guidance;
 10. Home health aides;
 11. Counseling by a Social Worker or pastoral counselor.
 - Not covered: Social Service Workers.
- J. Other Eligible Medical Expenses:
1. Prescription Drugs as provided by the Prescription Drug Card Service;
 2. Local professional Ambulance service for necessary transportation due to an accident or life threatening emergency or for treatment which cannot be performed at the Hospital in which the patient is confined.
Air ambulance, if determined to be Medically Necessary, to the nearest facility where care can be provided;
 3. Acupuncture to the extent that it is performed by a Physician;
 4. Temporomandibular Joint (TMJ) Disorder up to the maximum indicated in the Schedule of Benefits;
 5. Diagnostic infertility tests for determination of the condition and treatment of the medical condition if it is causing the infertility problem, including corrective Surgery;
 6. Allergy injections;
 7. Necessary Durable Medical Equipment rental, up to the amount of purchase of such equipment. Repair/replacement is subject to Medical Necessity and/or age of the equipment;

8. Wellness care as described in the Schedule of Benefits;
9. Transplants are reviewed with regard to Medical Necessity, the facility's recommendations and Physician documentation;
Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a Participant will be provided:
 - a. The recipient is covered under the Plan, the recipient and donor are covered;
 - b. A donor is covered under this Plan, the donor is covered only if the recipient's plan does not cover the donor.
10. Confinement in a rehabilitation facility must follow within twenty-four (24) hours of and be for the same or related cause(s) of a period of Hospital or Extended Care Facility confinement;
11. Reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician;
12. Pain management for chronic pain must be Medically Necessary and rendered by a covered Physician. Pain is chronic if it has occurred recurrently over months or years or persists longer than expected following an illness or Injury. Typically, pain is not considered chronic until it has persisted for three (3)–six (6) months or more. Multiple disciplinary pain management assessment and the submission of a treatment plan following the initial evaluation by a pain Physician will be required for pain management services. Preauthorization should be obtained;
13. Medically Necessary Care and treatment;
14. Pre-Admission/Pre-Surgical testing:
 - a. Must be within seven (7) days of Surgery;
 - b. If Surgery is postponed, testing is still considered Pre-Admission Testing if Surgery is performed within two (2) weeks.
15. Take home drugs from the Hospital and medications dispensed in the Physician's office;
16. Private duty nursing by a Registered Nurse (includes certified clinical specialists in psychiatric and mental health nursing);
17. Dietary counseling is covered if Medically Necessary due to diabetes, heart disease and/or morbid obesity with coexisting cardiac hypertensive and/or respiratory disease. Physician's written statement is required;
18. Initial pair of glasses or contacts in connection with cataract Surgery;
19. Office visits to prescribe and monitor birth control pills (for Employee and Spouse only);
20. Wigs/accessories when needed due to chemotherapy;
21. Jobst stockings; and
22. Treatment of sleep disorders including sleep apnea if Medically Necessary.

3.6 **Exclusions and Limitations.** The following services or charges shall not be considered Covered Medical Expenses under the Plan:

- A. Charges relating to any Pre-Existing Condition, pursuant to the provisions set forth in Article IV below;
- B. Transportation charges other than by a professional Ambulance service;
- C. Services rendered after termination of participation in the Plan;
- D. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with custodial care, education, or training, or expenses actually incurred by other persons except as specifically addressed under Covered Medical Expenses;
- E. Services needed due to war or any act of war, whether declared or undeclared;
- F. Services rendered resulting from or occurring during the commission or attempted commission of a felony crime, a felonious act or aggravated assault or while engaged in an illegal act. Exclusion will not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or domestic violence;
- G. Charges for services incurred outside the continental United States unless charges were incurred while traveling on business or for pleasure, or in the case of a Full Time Student, while studying abroad;
- H. Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits. This Plan pays secondary to such other plan;
- I. Services, care, treatment, and referrals rendered by the Participant's family including, but not limited to, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, grandson, granddaughter, or any person who resides with the Participant;
- J. Services rendered for treatment of any Sickness or Injury for which benefits are available under any workers' compensation employer liability law or services for any occupational Sickness or Injury. Occupational Sickness or Injury includes those as a result of any work for wage or profit;
- K. Charges for completion of claim forms;
- L. Charges billed by both Physician and Hospital for the same service (except for charges for Anesthesia which shall be paid to the Hospital and to the Physician based upon Usual, Customary and Reasonable Charges);
- M. Expenses in excess of the Usual, Customary and Reasonable Charge;
- N. Education classes, including charges for natural childbirth instruction;
- O. Services performed for cosmetic or reconstructive Surgery or complications of cosmetic or reconstructive Surgery procedures unless:
 - 1. The condition is necessary as the result of accident or Sickness;
 - 2. Scar revision due to accident or Sickness;
 - 3. Correction of congenital defects which interferes with bodily function;
 - 4. The services are performed during the period a Participant is participating under the Plan; and
 - 5. The services are for reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician.

- P. Any related expenses for a procedure not covered by the Plan;
- Q. Charges which are payable by any third party due to legal liability including, but not limited to, professional liability insurance, motor vehicle liability insurance, individual liability insurance, and any other source from which medical benefits would be paid if this Plan did not exist, whether or not legal action is taken on behalf of the Participant;
- R. Charges which the Participant would not be required to pay if he did not have group health coverage;
- S. Charges to the extent of coverage required by, or available through, any federal, state, municipal or other governmental body or agency, except as provided in paragraph 4.10 and except for medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid");
- T. Experimental/Investigative drugs, chemicals, services or procedures;
- U. Services provided by an entity not defined as an eligible Provider;
- V. Sexual conversion Surgery, sexual dysfunctions, or other services related to gender reassignment or disturbance of gender identification;
- W. Music therapy, vision therapy or remedial reading therapy or treatment for learning disabilities;
- X. Exercise equipment including bicycles, weights, ergometers, or other equipment not generally considered Durable Medical Equipment;
- Y. Charges and services related to a newborn who is not a participating Dependent;
- Z. Dental expenses except as specifically outlined in the Schedule of Benefits;
- AA. Sterilization expenses for dependent Children;
- BB. Sterilization reversals;
- CC. With respect to diagnostic testing:
 1. Tests performed more frequently than is necessary according to the diagnosis and accepted medical practice;
 2. Genetic testing unless family history necessitates;
 3. Premarital examinations;
 4. Duplicate testing by different Physicians unless Second Opinions are authorized herein; and
 5. Tests associated with routine visits except those covered under the Wellness benefit provision.
- DD. With respect to consultations:
 1. Telephone only consultations;
 2. Consultations for ineligible or unnecessary procedures; and
 3. Services rendered by practitioners other than Physicians.
- EE. With respect to infertility:
 1. Assisted reproductive technology such as invitro or invivo fertilization, artificial insemination, gamete inter-fallopian transfer (GIFT), ovum or embryo placement or transfer or any other impregnation procedure;
 2. Fertility drugs;
 3. Any treatment other than that which treats a medical condition;
 4. Diagnostic tests unless necessary to diagnose a medical condition; and
 5. Fertility supplies, treatment and counseling.
- FF. With respect to Hospital services:
 1. Room and Board Charges made by a facility other than a Hospital or Extended Care Facility;

2. Admissions for observation, rest, physical therapy, or testing;
 3. Weekend admissions except for Medical Emergencies;
 4. Charges for any period of confinement prior to the day before scheduled Surgery unless a documented hazardous medical condition exists; and
 5. Charges deemed not Medically Necessary by the Utilization Review Service and/or Claims Administrator.
- GG. Transplant expenses incurred for donor procurement to the extent exceeding the limits set forth in the Schedule of Benefits and the list of Covered Medical Expenses;
- HH. Visual acuity testing, visual correction other than cataract removal, by any means, including radial keratotomy, lasik Surgery and other Surgeries, exercise, eyeglasses, contact lenses, or orthoptic training;
- II. Replacement of prosthetic devices, except when required because of growth or other physiologic change or a change in the Participant's condition;
- JJ. Penile implants and/or any related expenses unless having organic origin;
- KK. Orthotics, unless deemed Medically Necessary by the Claims Administrator, orthopedic shoes or other supportive devices for the feet;
- LL. Care and treatment of any type of obesity, including Morbid Obesity, weight loss programs, exercise programs, medications and/or dietary consultations. This exclusion is applicable whether or not it is solely for the treatment of obesity or if a part of the treatment plan for another Sickness. Counseling services necessary related to eating disorders (ex. anorexia, bulimia) will be provided as detailed under the mental/nervous benefits;
- MM. Smoking cessation and any related services including nicorettes, patches (Nicoderm/Habitrol, etc.);
- NN. Hearing aids, implants, routine hearing testing or services necessary due to degenerative hearing loss not specifically caused by Sickness, congenital defect or trauma;
- OO. Biofeedback, services by an acupuncturist, or hypnotherapy;
- PP. Medical care claims filed more than twelve (12) months from the date of service;
- QQ. For any prescriptions covered under the drug card program;
- RR. Services due to intentional self-inflicted Injuries unless due to a medical condition (either physical or mental) or domestic violence;
- SS. Care and treatment that is deemed not Medically Necessary;
- TT. Marital and family counseling;
- UU. Surrogate parenting;
- VV. Taxes, postage, shipping and handling;
- WW. For removal of excess skin;
- XX. Bereavement counseling;
- YY. Corrective shoes or other corrective devices or appliances;
- ZZ. Transportation except covered Ambulance services;
- AAA. Education, training due to mental nervous, mental and emotional disorders, alcoholism and drug dependency;
- BBB. Charges due to operating a motor vehicle, watercraft or aircraft when due to:
1. Being under the influence of any narcotic to the extent mental or physical functioning is impaired unless the narcotic is administered on the advice of a Physician;

2. Having consumed alcohol causing an alcohol concentration of 0.08 or more; or
 3. Being intoxicated to the extent mental or physical functioning is appreciably impaired.
- CCC. Charges due to an illegal occupation;
- DDD. Wisdom teeth extractions;
- EEE. Developmental disorders such as but not limited to mental retardation, conduct disorders, dyslexia, learning disabilities (except attention deficit disorder) (A.D.D.), hyperactivity or hyperkinesis;
- FFF. Massage therapy by a massage therapist;
- GGG. Palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone Surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet. This exclusion does not include:
1. Partial or complete removal of nail roots; and
 2. Services prescribed by a Physician legally qualified to treat the patient for metabolic disease or peripheral vascular disease.
- HHH. Injuries due to intentional aggression;
- III. Birth control and birth control devices;
- JJJ. Physician charges related to birth control such as insertion/removal of IUD, fitting an IUD;
- KKK. Implantable contraceptive capsules (Norplant®); and
- LLL. Depo-provera injections.

ARTICLE IV

PARTICIPATION

- 4.1 **Eligibility for Benefits.** Individuals eligible to enroll in the Plan include:
1. Employees;
 2. Dependents; and
 3. Retired Employees.

Upon enrollment in the Plan pursuant to this section and payment of any required Employee Contribution, the Employee or Retired Employee, and, if applicable, his Dependent(s) shall become Participants eligible to receive benefits as provided by this Plan.

If both Spouses are Employees or Retired Employees of the Employer, both must elect to participate in this Plan as Employees or Retired Employees, but only one (1) Spouse may enroll their Dependents under the Plan. In no event may an individual participate both as an Employee or Retired Employee and as a Dependent under the Plan.

- 4.2 **Enrollment.** An Employee may enroll in the Plan within thirty-one (31) days of becoming an Employee as defined in Article XII by making written application for participation on such form(s) as may be prescribed from time to time by the Benefit Committee and by providing the Benefit Committee with such other information as may be requested.

Participation in the Plan by the Employee and, if applicable, his Dependent(s) shall be contingent upon receipt by the Benefit Committee of a completed enrollment form and any other information requested by the Benefit Committee and, if applicable, payment of any required Employee Contribution; provided, however, eligibility to enroll shall not be based on any of the following health-status related factors in relation to the Employee or his Dependent(s): (a) health status; (b) medical condition (including both physical and mental illness); (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability (including conditions arising out of acts of domestic violence); or (h) disability.

If an Employee enrolls in the Plan pursuant to this section, the Employee and, if applicable, his Dependent(s), shall become Participants effective the thirty-second (32nd) day after the Employee first becomes an Employee as defined herein. If the Employee and, if applicable, his Dependent(s), fail to enroll in the Plan within thirty-one (31) days of becoming eligible, the Employee and, if applicable, his Dependents must wait for the Plan's Open Enrollment Period to enroll in the Plan.

Late Enrollees will be enrolled in accordance with the same procedures, but shall be subject to the eighteen (18) month Pre-Existing Condition exclusion period. (See Pre-Existing Condition section.)

4.3 **Special Enrollment Procedure.**

- A. **Individuals Losing Other Coverage.** The Plan shall permit an Employee who is eligible for coverage under the terms of the Plan but not enrolled (or a Dependent of such an Employee if the Dependent is eligible for coverage under the Plan but not enrolled) to enroll for coverage under the Plan pursuant to this section if each of the following conditions is met:
1. The Employee or Dependent was covered under a Group Health Plan or Health Insurance Coverage at the time coverage under the Plan was previously offered to the Employee or Dependent;
 2. The Employee stated in writing at such time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment; provided, however, this condition shall apply only if the Employer required such a statement at the time coverage under the Plan was offered and provided the Employee with notice of such requirement and the consequences of failing to enroll at such time;
 3. The Employee's or Dependent's coverage described in subparagraph (A)(1) of this section: (i) was under a COBRA Continuation Provision and the coverage under such provision was exhausted; or (ii) was not under a COBRA Continuation Provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, the operation of a lifetime limit on all benefits, and in the case of group coverage provided through an HMO an individual no longer resides, lives, or works in the service area of the HMO (whether or not within the choice of the individual); and
 4. The Employee requests special enrollment under this section not later than thirty (30) days after the date of exhaustion of coverage described in

subparagraph (A)(3)(i) of this section or termination of coverage or employer contribution described in subparagraph (A)(3)(ii) of this section.

B. Dependent Beneficiaries.

1. If an Employee eligible to participate in the Plan is a Participant (or has met any Waiting Period applicable to becoming a Participant) and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period, and he acquires a Dependent through marriage, birth or adoption or Placement for Adoption, the following special enrollment period set forth in subparagraph (B)(2) of this section shall apply during which period such Employee and Dependent may be enrolled under the Plan, and in the case of the birth or adoption of a Child, the Spouse of the Employee may also be enrolled as a Dependent of such Spouse if otherwise eligible.
2. The Dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of: (i) the date Dependent coverage is made available under the Plan, or (ii) the date of the marriage, birth or adoption or Placement for Adoption, as the case may be, as described in subparagraph (B)(1) above of this section.
3. If an Employee described in subparagraph (B)(1) of this section seeks to enroll a Dependent during the first thirty (30) days of the Dependent special enrollment period, the coverage of the Dependent shall become effective: (i) in the case of marriage, the date of the marriage; (ii) in the case of a Dependent's birth, as of the date of such birth; or (iii) in the case of Dependent's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption.
4. If applicable, upon the enrollment of a Dependent under this Section 4.3B, the Employee may change Plan options, if any. Amounts incurred to satisfy Deductibles and Out-of-Pocket Maximums, if any, will be applied to the new option.

4.4 **Open Enrollment Period.** During the Plan's Open Enrollment Period, a nonparticipating Employee may elect to participate in the Plan singly or with his Dependents and a participating Employee may elect to add, modify or eliminate coverage under the Plan. Any changes elected during the Plan's Open Enrollment Period shall be effective as of the first day of the Plan Year immediately following the close of the Open Enrollment Period. Any new coverage elected during the Plan's Open Enrollment Period by an Employee who had not previously participated in the Plan shall be subject to the Plan's Pre-Existing Conditions limitation and all other terms and provisions of the Plan. Any modification elected by a participating Employee shall not be subject to a new Pre-Existing Condition limitation.

4.5 **Coverage Changes Due to a Life Event.** In addition to the special enrollment procedures set forth in Section 4.3 above, a participating Employee may change coverage from single to family or from family to single when there is a change in family status (a life event) by notifying the Human Resources Department within thirty (30) days of the change in family status.

The effective date of the change in coverage will be the date of the change in family status. Change in family status is defined as:

- A. Change in Legal Marital Status. Events that change an Employee's legal marital status, including the following: marriage, death of Spouse, divorce, legal separation and annulment.
- B. Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth, death, adoption and Placement for Adoption.
- C. Change in Employment Status. Any of the following events that change the employment status of the Employee, his Spouse, or Dependent: a termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, change in worksite or change in employment status with the consequence of the individual becoming (or ceasing to be) eligible under an employer's health plan.
- D. Dependent Satisfies or Ceases to Satisfy Eligibility Requirement. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance.
- E. Residence. A change in the place of residence of the Employee, Spouse or Dependent.
- F. Contributions. Cost changes resulting from increased or decreased Employee Contributions or employer contributions toward such coverage were terminated.
- G. Cost Decrease. Significant cost decrease.
- H. Open Enrollment. The Employee's plan or Spouse's plan holds an open enrollment.
- I. Medicare or Medicaid Entitlement. If a Participant, his spouse, or a dependent becomes enrolled for general benefits under Medicare or Medicaid the Participant shall be allowed to cancel coverage for such individual. Alternatively, if the Participant, spouse, or dependent loses coverage under Medicare or Medicaid, the Participant may make a prospective election to begin or increase coverage of that individual under the Participant's accident or health plan.

If necessary, an updated health care identification card will be issued upon receipt of revised Employee data.

4.6 **Enrollment Pursuant to Qualified Medical Child Support Orders.** Notwithstanding anything herein to the contrary, any Child of an Employee or a Retired Employee or of their Spouse participating in the Plan shall be enrolled in the Plan in accordance with the terms of any Qualified Medical Child Support Order. Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Orders from the Benefit Committee.

4.7 **Pre-Existing Conditions.**

- A. Except as provided in subparagraph (C) below, expenses incurred for treatment of a Pre-Existing Condition shall be excluded from coverage under the Plan and not considered Covered Medical Expenses if medical advice, diagnosis, care or treatment was recommended or received with respect to such Pre-Existing Condition within the six (6) month period ending on the Participant's Enrollment Date; provided, however, that such exclusion shall extend for a period of not more than twelve (12) months (or eighteen (18) months in the case of a Late Enrollee) after the Participant's Enrollment Date and the period of such Pre-Existing Condition exclusion shall be reduced by the aggregate of the periods of Creditable Coverage applicable to the Participant as of the Enrollment Date.

B. **Rules Relating to Crediting Previous Coverage.**

1. **Breaks in Coverage.** A period of Creditable Coverage shall not be counted with respect to enrollment under the Plan, if, after such period and before the Enrollment Date, there was a sixty-three (63) day period during all of which the individual had no Creditable Coverage. For purposes of this subparagraph (B)(1) of this section, any Waiting Period shall not be taken into account in determining the continuous period described in the preceding sentence. Periods of Creditable Coverage shall be established through presentation of certifications described in subparagraph (B)(3) below of this Section 4.7 or in such other manner as may be specified in regulations under ERISA.
2. **Method of Crediting Service.**
Standard Method. The Plan shall count a period of Creditable Coverage without regard to the specific benefits covered during the period.
3. **Certifications and Disclosure of Coverage.**
 - a. The Plan shall provide the Certificate of Creditable Coverage (COC) described in subparagraph (B)(1) of this section at the following times:
 - (1) At the time a Participant ceases to be covered under the Plan (including loss of coverage due to the operation of a lifetime limit on all benefits) or otherwise becomes covered under a COBRA Continuation Provision;
 - (2) In the case of a Participant becoming covered under a COBRA Continuation Provision, at the time the Participant ceases to be covered under such provision; and
 - (3) Upon the request of an individual made not later than twenty-four (24) months after the date of cessation of the coverage described in subparagraphs (A) or (B) of this section;
 - b. The certification shall be a written certification of the period of Creditable Coverage of the individual under the Plan and the coverage, if any, under the COBRA Continuation Provision and, if applicable, the Waiting Period imposed with respect to the individual for coverage under the Plan;
 - c. A Certificate of Creditable Coverage (COC) will be generated automatically upon termination. If additional certificates are needed, contact the Wells Fargo Third Party Administrators, Inc. Customer Service Department;
 - d. Written procedures for requesting and receiving a Certificate of Creditable Coverage may be obtained from the Plan Administrator.

C. **Exceptions to Pre-Existing Condition Exclusion.**

1. **Certain Newborns.** The Pre-Existing Condition exclusion described in subparagraph (A) of this section shall not apply in the case of an individual who, as of the last day of the thirty (30) day period beginning with the date of birth has Creditable Coverage; provided, however, this exception shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual did not have any Creditable Coverage.

2. **Certain Adopted Children.** The Pre-Existing Condition exclusion described in subparagraph (A) of this section shall not apply in the case of a Child who is adopted or Placed for Adoption before attaining age 18 and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or Placement for Adoption, has Creditable Coverage; provided, however, the prior sentence shall not apply to coverage before the date of such adoption or Placement for Adoption and, provided further, this exception shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual did not have any Creditable Coverage.
3. **Pregnancy.** The Pre-Existing Condition exclusion described above in subparagraph (A) of this section shall not apply to any Pre-Existing Condition relating to Pregnancy.

4.8 **Termination of Participation.** The participation of an Employee, Retired Employee and/or Dependent(s) in the Plan shall terminate as follows:

- A. **Employee and Retired Employee Participation:** Subject to the provisions of Section 4.2, the participation of an Employee or Retired Employee in the Plan shall terminate upon the first occurrence of any of the following events:
 1. An Employee or Retired Employee no longer meets the definition of Employee as set forth in Article XII or Retired Employee as set forth in Article XII, whichever is applicable, for any reason;
 2. Termination of the Plan;
 3. The Employee, or Retired Employee fails to make any required Employee Contributions;
 4. An Employee's absence from work due to the following will not cause termination of participation in the Plan until the end of a continuous period of time indicated below:
 - a. If the Employee is on an approved leave of absence and has sick leave available PROVIDED the Employee is not eligible to be covered under any other group health plan either as an Employee or as a Dependent; or
 - b. If the Employee is on leave pursuant to the Family and Medical Leave Act, participation in the Plan shall not terminate until such time as termination is permitted under such Act. For any other types of leave of absence, contact the Human Resources Department for further details.
- B. **Dependent Participation:** Subject to the provisions of paragraph 4.6, the participation of a Dependent in the Plan shall terminate upon the first occurrence of any of the following events:
 1. The Dependent no longer meets the definition of Dependent as set forth in Article XII;
 2. The Employee or Retired Employee ceases being a Participant in the Plan;
 3. Participation for Dependents in the Plan is terminated;
 4. The Dependent commences participation in the Plan as an Employee; or
 5. Any required contributions are not made.

4.9 **Continuation of Coverage (COBRA)**. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that certain Participants as specified below may elect to continue participation as a temporary extension of medical coverage (hereinafter "continuation coverage") upon payment of a monthly premium by the Participant in certain instances where participation in the Plan would otherwise be terminated.

It is the responsibility of an Employee, a participating Spouse or Dependent (hereinafter referred to as a "qualified beneficiary") to notify the Plan Administrator's Human Resources Department in writing of any of the following events within sixty (60) days of the event:

1. Divorce or legal separation from the Employee or Retired Employee;
2. Parents' divorce or legal separation;
3. The dependent Child ceases to be a Dependent as defined;
4. A second qualifying event that occurs while on COBRA;
5. Notice that a qualified beneficiary is entitled to a disability extension as provided under Section F. 2. b.; or
6. Notice that a qualified beneficiary is no longer disabled as determined by the Social Security Administration.

Failure to notify the Plan Administrator's Human Resources Department as required will result in the forfeiture of the qualified beneficiary's (as applicable) rights to continuation coverage.

All other qualifying events are the Employer's responsibility to notify the qualified beneficiary of their COBRA right following a qualifying event.

- A. A participating Employee may elect continuation coverage if participation in the Plan terminates because of a reduction in the number of hours of employment or the termination of employment for reasons other than gross misconduct.
- B. A participating Spouse may elect continuation coverage if participation in the Plan terminates for any of the following reasons:
 1. The death of the Employee or Retired Employee;
 2. Reduction in the Employee's hours of employment or termination of the Employee's employment for reasons other than gross misconduct;
 3. Divorce or legal separation from the Employee or Retired Employee; or
 4. The Employee or Retired Employee becomes entitled to Medicare and this causes a loss of coverage under the Plan.
- C. An Employee's or Retired Employee's dependent Child participating in the Plan may elect continuation coverage if participation in the Plan terminates for any of the following reasons:
 1. The death of the Employee or Retired Employee;
 2. Termination of the Employee's employment for reasons other than gross misconduct or a reduction in the Employee's hours of employment;
 3. Parents' divorce or legal separation;
 4. The Employee or Retired Employee becomes entitled to Medicare and this causes a loss of coverage under the Plan;
 5. The dependent Child ceases to be a Dependent as defined; or
 6. Dependents of Employees who are already eligible for Medicare on the date of termination may have the greater of eighteen (18) months from the Employee's termination date or the balance of thirty-six (36) months from the Employee's Medicare entitlement date.

- D. A Retired Employee and his Dependent(s) participating in the Plan (including a surviving Spouse of a former Retired Employee) may elect continuation coverage if participation in the Plan terminates due to a proceeding in a case under Title 11 of the United States Code (hereinafter "Bankruptcy Proceeding.") For these purposes, participation in the Plan is deemed to terminate if there is a substantial elimination of coverage under the Plan within one (1) year before or after the date of commencement of the Bankruptcy Proceeding.
- E. If continuation coverage is elected pursuant to subparagraphs A, B, C or D above by a Participant, a participating Spouse or Dependent, Plan benefits shall be identical to those available under the Plan to similarly situated Participants.
- F. Duration of Continuation Coverage
1. A qualified beneficiary is entitled to maintain continuation coverage for thirty-six (36) months unless the qualified beneficiary's participation in the Plan terminates as a result of a termination of employment or reduction in hours.
 2. A qualified beneficiary is entitled to maintain continuation coverage for eighteen (18) months if the qualified beneficiary's participation in the Plan terminates as a result of a termination of employment or reduction in hours. Provided, however, that:
 - a. This eighteen (18) months may be extended to thirty-six (36) months from termination of employment (or reduction in hours) if other events (such as death of the Employee, divorce, legal separation, or Medicare entitlement and this causes a loss of coverage under the Plan) occur during such eighteen (18) month period (Premium will be equal to 102% of the cost of Plan coverage); and
 - b. This eighteen (18) months may be extended to twenty-nine (29) months if the qualified beneficiary is determined to be disabled (for Social Security disability purposes) within the first sixty (60) days of COBRA coverage and the Plan Administrator is provided with a copy of the disability determination award letter within sixty (60) days thereof and before the end of the eighteen (18) months (150% of the cost of Plan coverage may be charged for the last eleven (11) months). Such twenty-nine (29) month maximum disability coverage period shall apply to each qualified beneficiary who is entitled to continuation coverage because of such qualifying event, including the qualified beneficiary who is disabled and each qualified beneficiary who is not disabled.
 3. Except as provided in subparagraph 4 below, in no event shall continuation coverage last beyond thirty-six months from the date of the event that originally made the qualified beneficiary eligible to elect continuation coverage.
 4. In the event of the Employer's commencement of a Bankruptcy Proceeding, the duration of the continuation coverage shall be as follows:
 - a. A Retired Employee, or if applicable, the surviving Spouse of a former Retired Employee is entitled to maintain continuation coverage for his or her life, and
 - b. The Spouse of a Retired Employee and any dependent children of a Retired Employee are entitled to maintain continuation coverage until

the Retired Employee dies, at which time they are entitled to maintain continuation coverage for an additional thirty-six (36) months from the date of the Retired Employee's death.

- G. Continuation coverage shall terminate prior to expiration of the applicable time period set forth in subparagraph F, above, upon occurrence of any of the following events:
1. The Employer ceases to provide any Group Health Plan;
 2. The premium for the continuation coverage is not paid by the qualified beneficiary in a timely manner as defined in paragraph L;
 3. The qualified beneficiary (other than a qualified beneficiary electing continuation coverage pursuant to subparagraph 4 above) becomes entitled to Medicare after the date he elects COBRA coverage;
 4. The qualified beneficiary becomes covered after the date he elects COBRA coverage under another Group Health Plan, which does not contain any exclusion or limitation with respect to any Pre-Existing Condition of such qualified beneficiary. If the qualified beneficiary has enough creditable coverage to eliminate the Pre-Existing Condition exclusion or limitation, coverage will be discontinued; or
 5. The qualified beneficiary has extended continuation coverage for up to twenty-nine (29) months due to disability, and there has been a final determination that the qualified beneficiary is no longer disabled. The qualified beneficiary must notify the Plan within thirty (30) days of the determination.
- H. Each qualified beneficiary must be offered the opportunity to make an independent election of COBRA continuation coverage. If a qualified beneficiary makes an election to provide a Dependent with COBRA continuation coverage, such election shall be binding on other Dependents.
- I. An individual is not a qualified beneficiary if, on the day before a qualifying event, the individual is covered solely by reason of another's COBRA continuation coverage and is not already a qualified beneficiary by reason of a prior qualifying event, except that children born to, adopted by or Placed for Adoption with a covered Employee (or former Employee) who is a qualified beneficiary while COBRA coverage is in effect shall become qualified beneficiary if such covered Employee (or former Employee) notifies the Benefit Committee in writing within thirty (30) days of the birth, adoption or Placement for Adoption and pays any applicable premiums.
- J. A qualified beneficiary will receive a written notice of the right to elect continuation coverage within fourteen (14) days of notice of a qualifying event. Such notice will state the amount of the payments required for the continuation coverage. The qualified beneficiary may elect continuation coverage no later than sixty (60) days after the later of:
1. The date of termination of participation as a result of the qualifying event; or
 2. The date he is sent notice of his right to elect continuation coverage.
- K. Failure to elect COBRA coverage during the sixty (60) day election period relieves the Employer from the obligation to provide COBRA continuation coverage.

- L. Payment of the required COBRA premium (calculated from the eligibility date) is as follows:
1. The premium must be made within forty-five (45) days of the election.
 2. The initial payment for the COBRA premium will cover the period from the eligibility date through the current premium cycle.
 3. Afterwards, the Participant will need to pay the monthly premium to remain eligible through the applicable time period.
 4. Failure to pay the initial or the monthly premium on a timely basis will forfeit the Participant's right to COBRA coverage and he cannot be reinstated.
 5. If timely payment is made to the Plan and the amount is an insignificant shortfall (no more than the lesser of \$50 or 10% of the required premium amount), the Participant will be notified of the discrepancy and will be provided an additional thirty (30) days to submit the payment in full. For example, suppose a COBRA Participant pays \$275 for a \$300/month premium, and the payment arrives thirty (30) days after the due date. This shortfall is insignificant, so the Plan must either treat the \$275 amount as payment in full, or notify the Participant of the shortfall and provide an additional thirty (30) days for payment. On the other hand, if the Participant pays \$260 on the last day for which payment is initially due, the Plan could terminate his coverage.
 6. The amount of the COBRA premium charged can be increased only as provided in federal regulations.
- M. The Trade Act of 2002 amended COBRA to provide a second sixty (60) day COBRA election period for certain eligible individuals. They must be eligible for trade adjustment assistance (TAA) or alternate trade adjustment assistance (ATAA), and not have elected COBRA during the initial sixty (60) day election period that directly followed an ATAA/TAA-related loss of coverage. The intent of this second sixty (60) day election period is to enable those individuals who became TAA or ATAA-eligible after their initial COBRA election period has expired to take advantage of the Health Coverage Tax Credit (HCTC). These new COBRA provisions are effective for individuals whose successful petitions to TAA or ATAA were filed on or after November 4, 2002.

The process for determining individual TAA/ATAA certification begins when Employees (or their representatives) petition to the Department of Labor to recognize their Employer as being adversely affected by trade. Generally, an Employer can become TAA/ATAA-certified if the Employer meets the following criteria:

1. Employees have been totally or partially laid off (a partial layoff means a reduction in hours and wages to 80% or less per week);
2. Sales or production have declined due to trade; and
3. Increased imports have contributed to Employee layoffs.

If the Department of Labor approves the petition, the Employees are notified in writing by their local state workforce agency. Once the Employees receive notification, they may apply for TAA or ATAA benefits on an individual basis.

Individuals are potentially HCTC-eligible under TAA when they are either

receiving Trade Readjustment Assistance (TRA) benefits or are eligible to receive TRA payments but have not yet exhausted unemployment insurance benefits.

Individuals are potentially HCTC-eligible under ATAA when they are eligible to begin receiving their ATAA benefits.

- The additional sixty (60) day COBRA election period is available to TAA and ATAA recipients, but not to individuals eligible for the HCTC through the PBGC.
- The additional sixty (60) day COBRA election period begins on the first day of the month in which the individuals becomes an eligible TAA or ATAA recipient (when they first become eligible to receive TRA payments or ATAA benefits, respectively). Because the sixty (60) day period is measured from the first day of the month, if an individual is determined TAA/ATAA eligible after the first day of the month, then they will have less than sixty (60) days to elect COBRA.
- In addition, the election period could be shorter in certain circumstances because individuals are required to make an election within six (6) months following the initial TAA/ATAA-related loss of coverage.
- COBRA coverage elected during the second election period is not retroactive to the date of the initial loss of coverage. It begins on the first date of the second COBRA election period (However, the lapse in coverage from the initial loss date to the start of the second election period is not counted as a lapse in coverage for the purposes of the HIPAA sixty-three (63) consecutive day lapse in coverage rule).

N. Continuation coverage under the Uniformed Services Employment and Re-employment Rights Act (USERRA).

1. In any case in which an Employee and/or qualified beneficiary has coverage under this Plan, and such person is absent from such position of employment by reason of service in the uniformed services, the Plan shall provide that the person may elect to continue such coverage as follows. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - a. the twenty-four (24) month period beginning on the date on which the person's absence begins; or
 - b. the day after the date on which the person fails to apply for or return to a position of employment.
2. A person who elects to continue health-plan coverage under this Section shall be required to pay 102% of the full premium under the Plan associated with such coverage for the Employer's other Employees, except that in the case of a person who performs service in the uniformed services for less than thirty-one (31) days, such person shall not pay more than the Employee's share, if any, for such coverage.
3. In the case of a person whose coverage under a health plan was terminated by reason of service in the uniformed services, an exclusion or waiting period may not be imposed in connection with the reinstatement of such coverage upon re-employment if an exclusion or waiting period would not have been imposed under a health plan had coverage of such person by such plan not been terminated as a result of such service. This paragraph

applies to the person who is re-employed and to any individual who is covered by this Plan by reason of the reinstatement of the coverage of such person. This Paragraph 3 shall not apply to the coverage of any illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

4.10 **Integration With Medicare.** Employees or Spouses who are 65 years of age or older have a choice regarding health care coverage. Such Employees or Spouses may elect to participate in the Plan, or reject such participation and choose Medicare.

A. **Plan as Primary Payor.** If the Employee or Spouse chooses the Plan as the primary payor, the Plan shall pay the same benefits as if the Employee or Spouse were under age 65, and any unpaid medical expenses may be coordinated with Medicare as the secondary payor; however, Medicare shall be the primary payor for Employees and Dependents participating in the Plan who are eligible for Medicare disability benefits, unless the plan is deemed a "large group health plan" as defined by 42 U.S.C. Section 1895y(b)(2)(B)(iv).

B. **Medicare.** If the Employee or Spouse rejects the Plan, Medicare shall be the only payor and the Plan shall not pay benefits. Medicare shall be the primary payor for Participants who are eligible for Medicare disability benefits; provided, however, that if an Employee is participating in this Plan as a result of his current employment status with the Employer, or if a Spouse or Dependent is participating hereunder as a result of a participating Employee's current employment status with the Employer, the Employee, Spouse or Dependent, as applicable, will have a choice regarding primary coverage. In this latter instance, such Employee, Spouse or Dependent may elect to participate in the Plan, in which case the Plan shall be the primary payor, or may reject such participation and choose Medicare to be primary payor.

End Stage Renal Disease. If a participating Employee or Dependent becomes eligible for Medicare on the basis of end-stage renal (kidney) disease (ESRD), then the Plan will be the primary payor for the applicable coordination period as it is then defined under federal law (currently thirty (30) months for individuals who become Medicare eligible due to ESRD on or after October 31, 1997), and Medicare will be secondary. After the expiration of the coordination period, Medicare will be the primary payor and the Plan will be secondary. Provided, however, that if Medicare is already the primary payor (on the basis of age or disability) for a Participant who becomes eligible for Medicare due to ESRD, then Medicare will remain the primary payor. However, after electing COBRA, if the qualified beneficiary should become entitled to Medicare due to ESRD, the qualified beneficiary is no longer eligible for COBRA coverage.

ARTICLE V

PRECERTIFICATION OF SERVICES

5.1 **Scope of Precertification Review.** Benefits payable under the Plan relating to those services identified in section 5.2, paragraph B, are subject to the Precertification review procedures. Benefits shall be payable only for Covered Medical Expenses and the Precertification review procedures shall not in any manner be construed as expanding the eligible benefits payable under the

Plan.

5.2 **Precertification Review Procedures**. The Precertification review procedures are as follows:

- A. The Participant must advise the Physician of the Plan's Precertification review program;
- B. Except as provided in subparagraph C below, the Provider or the Participant must request approval from the Utilization Review Service **prior to** any of the following:
 - 1. Any non-emergency Inpatient Surgery;
 - 2. Any non-emergency Inpatient admission;
 - 3. Any non-emergency Inpatient and Partial Day Psychiatric Services;
 - 4. Any non-emergency Inpatient Rehabilitation admission;

NOTE: Precertification is not required for Medicare primary Participants.

NOTE: This Plan will accept another carrier's primary Precertification if this Plan is the secondary plan.

- C. In the case of Emergency Surgery or a Medical Emergency, the Provider or Participant must notify the Utilization Review Service within forty-eight (48) hours of the admission.

NOTE: **Precertification is not required for any Hospital length of stay in connection with childbirth for the mother or newborn Child if less than or equal to forty-eight (48) hours following a normal vaginal delivery or less than or equal to ninety-six (96) hours following a cesarean section. Hospital lengths of stay exceeding these time periods require Precertification.**

- D. No benefits will be provided under the Plan for Surgery or Inpatient admissions commencing on a Friday or Saturday, except in the following circumstances:
 - 1. The Inpatient admission or Surgery results from a bodily Injury or Sickness that occurs without warning and requires immediate Inpatient medical treatment to prevent death, disability or serious impairment of patient function;
 - 2. The Inpatient admission or Surgery is for care related to Pregnancy and is expected to result in childbirth or other termination of Pregnancy;
 - 3. Covered Surgery is performed within twenty-four (24) hours after the Participant is admitted; or
 - 4. Medically Necessary Inpatient medical services are rendered within twenty-four (24) hours after the Participant is admitted.
- E. The Utilization Review Service shall notify the Provider and Participant as to whether the services are approved or whether further information is necessary. In the case of Emergency Surgery or a Medical Emergency, the Utilization Review Service shall determine whether the Emergency Surgery was in fact required or whether a Medical Emergency in fact existed. Written confirmation of the Utilization Review Service's decision shall be mailed to the Provider(s) and the Participant.
- F. If the Utilization Review Service approves the services, including any Emergency Surgery and/or Inpatient admission that is the result of a Medical Emergency, an initial length of stay will be assigned. Any extension beyond the initial assignment must be requested by the Provider prior to the end of the initially assigned length of stay. If the admission is for a longer stay than approved, benefits under the Plan may be reduced as listed in the Schedule of Benefits.

5.3 **Failure to Follow Precertification Review Procedures.** If a Participant fails to follow the Precertification review procedures of Section 5.2, the benefits payable will be subject to the penalty detailed in the Schedule of Benefits.

5.4 **Denial by Utilization Review Service.** If approval of any services is denied by the Utilization Review Service, the Participant may file a written appeal with the Claims Administrator within one hundred eighty (180) days of the denial. An appeal should include any supporting facts that would clarify or strengthen the Participant's request for Precertification approval.

5.5 **Precertification and Preauthorization.** A Precertification is required to validate the Medical Necessity and the length of stay for the condition. A Preauthorization may be obtained to determine if the procedure is a Medically Necessary procedure and what benefits are available. Neither a Precertification nor a Preauthorization guarantees that the procedure is Medically Necessary or guarantees coverage under the Plan.

If a Participant is being case managed and alternative treatment options are recommended that are not usually covered by the Plan, the Plan has the right to authorize coverage for these situations. Alternate cost effective forms of care, treatment or treatment facilities may be recommended as part of the Case Management Program. Payment for these expenses not covered as a network provider under the Plan which are recommended by a Case Manager may be covered by the Plan Sponsor with pre-approval of the Plan Sponsor to consider these services at an in network rate.

ARTICLE VI

COORDINATION OF BENEFITS

6.1 **Purpose.** The purpose of this Article is to coordinate the payment of benefits between this Plan and one (1) or more other plans. By coordinating the payment of benefits of those Participants having coverage with one (1) or more group plans, maximum benefits for services may be provided by paying up to but not more than 100% of the Covered Medical. In some cases payment will be less than 100%.

6.2 **Primary and Secondary Plans.** The group plan which determines its benefit payment first and pays its full allowances is called the primary plan.

The benefit plan which determines its benefit payment after the other plan(s) is called the secondary plan. Secondary plan benefit payments are limited so that the total amount from all group plans will not be more than the actual amount of covered expenses incurred by the Participant.

If the Participant has additional group coverage which is primary, the secondary medical care plan(s) may pay the remaining balance (or a portion of the balance) for covered services after the primary Plan payment. The amount considered under the secondary plan will be limited to Plan maximum benefit levels.

Example: Covered charge is \$1,500 and the benefit is 80%.

Covered Charge = \$1,500

Primary payor's payment	=	- 900
Balance remaining	=	\$ 600
Secondary Plan will pay	=	\$ 600

In NO event will a Participant receive benefit payments greater than the cost of the covered expenses.

6.3 **Eligible Plans.** Medical plans providing benefits or service for treatment and coordinated with this Plan include:

- A. Any group, blanket or franchise insurance plan whether insured or uninsured;
- B. Any Hospital or medical service plan or any group practice or prepayment plan;
- C. Any union welfare or labor management trusted insurance plan;
- D. Any government insurance plan or coverage required by law subject to the provisions of Section 4.6 of this Plan and provided further that medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid") will not be taken into account; or
- E. Any automobile coverage covering a Participant including, but not limited to, Personal Injury Protection, NO Fault or Med-pay coverage.

6.4 **Ineligible Plans.** Individual insurance policies not listed above for which premiums are paid by the Participant directly to the organization providing coverage will not be coordinated with this Plan.

6.5 **Order of Benefit Determination.** If a Participant is covered by two (2) eligible plans (one (1) of which is this Plan) and both plans have a provision for coordination of benefits, the amount each plan pays and the order of payment of benefits will be as follows:

- A. The plan covering the Participant as an Employee is the primary plan;
- B. The plan covering the Employee as a Dependent is the secondary plan;
- C. If the parents of a participating dependent Child are not separated or divorced and the dependent Child is covered under both plans as a Dependent, the primary plan will be the one which covers the individual as a Dependent of the parent whose birthday falls earlier in the Calendar Year, irrespective of the year of birth;
- D. If the parents of a participating dependent Child are separated or divorced and the parent having custody of the dependent Child has not remarried, the benefit plan of the parent having Child custody shall be considered as the primary plan;
- E. If the parents of a participating dependent Child are divorced and the parent having custody of the dependent Child has remarried:
 - 1. The plan covering the dependent Child of the parent with custody shall be primary;
 - 2. Then the plan covering the Child as a Dependent of a Spouse of the parent with custody shall be secondary;
 - 3. Third, the plan of a parent without custody shall apply.
- F. Notwithstanding paragraphs D and E of this section, if there is a Qualified Medical Child Support Order which establishes the financial responsibility of a parent for health or dental care expenses for the Child, that parent's plan shall be considered as the primary plan;
- G. If joint custody does not establish responsibility for health care or dental expenses of

a participating dependent Child, the primary plan will be the one (1) which covers the dependent Child as a Dependent of the parent whose birthday falls earlier in the Calendar Year, irrespective of the year of birth;

- H. Except as provided in paragraphs C through G of this section, the plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before those of a plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored;
- I. If paragraphs A through H of this section do not apply, the plan which has covered the individual for the longest period of time will be considered as the primary plan;
- J. Notwithstanding any provision herein to the contrary except paragraph F of this section, in the event coverage by a plan does not provide for the coordination of benefits, that plan will be considered the primary plan, and this Plan is considered the secondary plan; and
- K. Auto coverage required by a motor vehicle accident reparations act (no fault auto plan) or similar law will be considered primary.

6.6 **Payment of Benefits.** If this Plan is primary, it will pay benefits as outlined. If this Plan is secondary, benefits will be calculated per the Plan's provisions after receipt of the primary payor's explanation of benefits.

6.7 **Right to Receive and Release Necessary Information.** For the purpose of determining the applicability of and implementing the terms of this section or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any other organization or person any information with respect to any person which this Plan deems to be necessary for these purposes. Any person claiming benefits under this Plan will furnish to this Plan any information necessary to implement this section.

ARTICLE VII

ADMINISTRATION

7.1 **Appointment of Committee.** The Plan shall be administered by a Benefit Committee of the Plan Administrator consisting of at least three (3) persons who shall be appointed by and serve at the pleasure of the Plan Administrator.

7.2 **Claims Processing Procedures.** This section describes in detail what to do in order to receive benefits under this Plan. The Employee should contact the Human Resources Department for additional information.

Claims should be mailed to the address indicated on the Employee's identification card(s).

A. **Definitions.** The following definitions apply for purposes of these Claims Processing Procedures:

1. Adverse benefit determination - a denial, reduction or termination of, or a failure to provide or make payment in whole or in part for a benefit.
2. Claimant - a Participant who files a claim under the Plan.
3. Post-service claim - any claim for a benefit under the Plan that is not a pre-service claim or urgent care claim.
4. Pre-service claim - any claim for a benefit under the Plan that is conditioned, in whole or in part, upon the approval of the benefit in advance of obtaining Medical Care.
5. Urgent Care Claim - any claim for Medical Care or treatment which if decided within the time period for pre-service claim determinations could seriously jeopardize the Claimant's life, health or ability to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care.

Any term not defined shall have the meaning set forth in the Plan, unless otherwise required by the federal regulations regarding claims procedures for Group Health Plans.

B. **Filing Claims.** A Claimant must file a written claim for benefits under the Plan with the Plan Administrator no later than twelve (12) months from the date of service. The written claim shall be made on such form(s) as may be prescribed from time to time by the Plan Administrator and shall include such information as requested on the claims form.

If a Claimant fails to follow the Plan's procedures in filing a pre-service claim for benefits, he will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Claimant or authorized representative. This notification will be provided no later than five (5) days following the date of the Claimant's failure to follow the Plan's procedures (or twenty-four (24) hours in the case of an urgent care claim). However, notification of a failure to follow the Plan's procedures in filing a claim will be provided only if the Claimant has submitted the claim to the Plan Administrator and has named a specific Claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

C. **Claim Notifications.**

1. **Time for Providing Notification.** The Plan Administrator will furnish notice of its benefit determinations under the Plan in accordance with the following provisions. For purposes of determining the time periods specified below, the period of time within which a benefit determination is required to be made will begin at the time the claim is received in accordance with the Plan's procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time to provide notification is extended due to a Claimant's failure to submit information necessary to decide a claim,

the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. A Claimant may also voluntarily agree to provide the Plan additional time within which to make a decision on a claim beyond the time limits specified below, including urgent care claims.

- a. **Urgent Care Claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) involving a claim for urgent care as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim. However, if a Claimant fails to provide sufficient information for the claims determination, the Claimant will be notified as soon as possible, but not later than twenty-four (24) hours, after receipt of the claim of the specific information necessary to complete the claim. The Claimant will be provided a reasonable amount of time, but not less than forty-eight (48) hours, to provide the specified information. The Claimant will then be notified of the Plan's benefit determination as soon as possible, but not later than forty-eight (48) hours after the earlier of: (a) the Plan's receipt of the specified information; or (b) the end of the period afforded to provide the specified additional information.
- b. **Pre-Service Claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination for a pre-service claim (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Plan. This period may be extended one (1) time by the Plan for up to fifteen (15) days if the Plan Administrator determines that this extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to a Claimant's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.
- c. **Post-Service Claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination for a post-service claim within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one (1) time by the Plan for up to fifteen (15) days if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the extension is

necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

- d. **Concurrent Care Decisions.** If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) *before* the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours of receipt of the claim by the Plan, as long as any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If such request involving urgent care is not made by the Claimant at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and will be decided in accordance with the above urgent care timeframes. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Plan does not involve an urgent care claim, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, i.e., as a pre-service claim or a post-service claim.

2. **Manner and Content of Notification of Benefit Determination.** The Plan Administrator will provide a Claimant with written or electronic notification of any adverse benefit determination, except that in the case of an adverse benefit determination involving a claim for urgent care, the notification may be provided to the Claimant orally as long as a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification. The notification will include the following:
- a. The specific reason(s) for the adverse determination;
 - b. Reference to the specific Plan provisions on which the determination is based;

- c. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- d. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimants right to bring a civil action following an adverse benefit determination on review;
- e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request;
- f. If an adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- g. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

D. **Appeal of Adverse Benefit Determination.**

1. **Review Procedures.** If a Claimant is notified of an adverse benefit determination, the Claimant or his authorized representative may make a written request for review of the determination by submitting such request to the Plan Administrator, c/o Wells Fargo Third Party Administrators, Inc., P.O. Box 366, Charleston, WV, 25322 within 180 days after notification of the adverse benefit determination, except in the case of any reduction or termination of a course of treatment (other than by Plan amendment) *before* the end of the previously approved period or number of treatments, the Plan Administrator will provide the Claimant sufficient advance notice of the reduction or termination to allow the Claimant to appeal and obtain a determination before the benefit is reduced or terminated (which period is not required to be 180 days).

A Claimant's written request for review will be forwarded by Wells Fargo Third Party Administrators, Inc. to the Benefit Committee for a full and fair review. The Claimant will be provided the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Claimant will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. The Benefit Committee will conduct its review without deference to the initial benefit determination and taking into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information

was submitted or considered in the initial benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Benefit Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor a subordinate of such individual. The Benefit Committee will also provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim involving urgent care, the Benefit Committee will provide for an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

2. **Timing of Notification of Benefit Determination on Review.** The Plan Administrator will notify a Claimant of the Plan's benefit determination on review as follows. For purposes of determining the time periods specified below, the period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the Plan's procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.
 - a. **Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan. However, if the requested services have already been provided between the time the claim was denied and a request for review is filed, the claim no longer involves urgent care and will be processed on review as a post-service claim.
 - b. **Pre-Service Claims.** In the case of a pre-service claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time

appropriate to the medical circumstances, but not later than thirty (30) days after receipt by the Plan of the Claimant's request for review.

- c. **Post-Service Claims.** In the case of a post-service claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

3. **Manner and Content of Notification of Benefit Determination on Review.** The Plan Administrator will provide a Claimant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification will set forth the following:

- a. Specific reason(s) for the adverse determination;
- b. Reference to the specific Plan provisions on which the benefit determination is based;
- c. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
- d. A statement describing voluntary appeal procedures offered by the Plan (if any);
- e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request;
- f. If an adverse benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- g. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

NOTE: Appeals should be mailed to Plan Administrator, c/o Wells Fargo Third Party Administrators, Inc., P.O. Box 366, Charleston, WV 25322.

- E. **Authorized Representative.** A Claimant is permitted to designate an authorized representative to act on behalf of a Claimant with respect to a benefit claim or appeal of an adverse benefit determination. Designation of an authorized

representative must be made in writing on such form as the Claims Administrator will provide from time to time and must be signed by the Claimant. However, in the case of an urgent care claim, the Plan will permit a health care professional with knowledge of the Claimant's condition (such as a treating Physician) to act as the authorized representative of the Claimant. This provision in the case of urgent care claims is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the Claimant is unable to act on his or her own behalf.

If a Claimant designates an authorized representative to act on his behalf as provided above, the Plan will direct all information and notifications to which the Claimant is otherwise entitled to the authorized representative with respect to the aspect of the claim for which the representative is designated (for example, initial determination, request for documents, appeal, etc.), unless the claimant directs otherwise.

- F. **Payment of Claims.** The above Claims Processing Procedures address only the time frames within which claims must be decided and not the periods within which payments that have been granted must be actually paid.
- G. **Amendment of Claims Procedures.** The Employer reserves the right to amend these claims and payment procedures at any time in whole or in part in accordance with the amendment procedures set forth in the Plan.

7.3 **HIPAA Privacy. Use and Disclosure of Protected Health Information (PHI).**
A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you and is available from the Human Resources Department.

This Plan, and the Employer or Plan Sponsor will not use or further disclose PHI that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA privacy rules. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer or Plan Sponsor.

Under HIPAA, you have certain rights with respect to your PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA privacy rules. For a copy of the notice, if you have questions about your PHI or if you wish to file a complaint under HIPAA please contact the Privacy Official or other Benefits Official of your Employer.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits which relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
2. Adjudication of health benefit claims (including appeals and other payment disputes);
3. Subrogation of health benefit claims;
4. Establishing Employee Contributions;
5. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
6. Billing, collection activities and related health care data processing;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
8. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
9. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
10. Utilization review, including Precertification, Preauthorization, concurrent review and retrospective review;
11. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the Provider and/or health plan); and
12. Reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating Provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvements of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to the

implementation of and compliance with HIPAA administrative simplification requirements;

8. Customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers;
9. Resolution of internal grievances; and
10. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

- A. **The Plan May Use and Disclose PHI for Treatment, Payment and Operations, as Required by Law and as Permitted by Authorization of the Participant or Benefit.** The Plan may, without the consent or authorization of the individual, use and disclose PHI for health care treatment, health care payment, and health care operations, and for such other uses or disclosures to the full extent permitted by regulations promulgated by the Secretary of Health and Human Services to implement HIPAA, subject to more stringent state privacy laws which do not conflict with HIPAA (if any).

The Plan may also disclose PHI to such other persons and for such other purposes when authorized by the individual on a form and in a manner provided for in regulations promulgated by the Secretary of Health and Human Services to implement HIPAA.

The Plan may also disclose summary health information to the Plan Sponsor if requested by the Plan Sponsor for the purpose of obtaining bids from health plans for providing health insurance coverage, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

- B. **For Purposes of this Section City of Goldsboro is the Plan Sponsor.** The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

- C. **With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions.** The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
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. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- 4. Not use or disclose PHI in connection with any other benefit or Employee benefit plan of the Plan Sponsor unless authorized by an

individual;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

D. **Adequate Separation Between the Plan and the Plan Sponsor Must be Maintained.** In accordance with HIPAA, only the following classes of Employees may be given access to PHI:

1. The benefits manager;
2. Staff designated by the benefits manager;
3. Claims processors.

E. **Limitations of PHI Access and Disclosure.** The persons described in Paragraph D of this Section may only have access to and use and disclose PHI for plan administration functions which the Plan Sponsor performs for the Plan.

F. **Noncompliance Issues.** If the persons described in Paragraph D of this Section do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

7.4 **HIPAA Security.** This section is intended to bring the City of Goldsboro Employee Group Health Plan (hereinafter "Plan") into compliance 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, 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.

A. **Definitions.**

1. **Electronic Protected Health Information.** - Is 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.
2. **Plan Documents.** - The Group Health Plan's governing documents and instruments (*i.e.*, the documents under which the Group Health Plan was

established and is maintained), including but not limited to the City of Goldsboro Group Health Plan Document.

3. **Plan Sponsor.** - The entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is City of Goldsboro.
4. **Security Incidents.** - Is 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.

B. 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:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. 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
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware.

7.5 **Records and Reports.** The Benefit Committee shall exercise such authority and responsibility as it deems appropriate in order to comply with all applicable laws and governmental regulations issued thereunder relating to records of Participants. The Claims Administrator shall provide to the Benefit Committee notifications to Participants or Employees, information for annual reports to be filed with the Internal Revenue Service, information for annual reports to the Department of Labor and any other necessary record keeping or reporting information.

7.6 **Other Benefit Committee Powers and Duties.** The Benefit Committee shall have such duties and powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

- A. To construe and interpret the Plan in its absolute discretion and to determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to deciding all disputes of eligibility and determining the amount, manner and time of payment of any benefits hereunder. Any such actions, determinations or decisions of the Benefit Committee shall presumptively be conclusive and binding on all persons;
- B. To prescribe procedures to be followed by Participants filing applications or claims for benefits;

- C. To prepare and distribute, in such manner as the Benefit Committee determines to be appropriate and in accordance with applicable laws, information explaining the Plan;
- D. To receive from the Employer and from Participants such information as may be necessary for the proper administration of the Plan;
- E. To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments of the Claims Administrator and reports of disbursements for expenses directed by the Committee; and
- F. To appoint or employ individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel.

7.7 **Rules and Decisions.** The Benefit Committee may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Benefit Committee shall be uniformly and consistently applied to all Participants in similar circumstances. In making a determination or calculation, the Benefit Committee shall be entitled to rely upon information furnished by the Participant, the Employer, the legal counsel of the Employer, or the Claims Administrator.

7.8 **Benefit Committee Procedures.** The Benefit Committee may act at a meeting or in writing without a meeting. The Benefit Committee shall elect one (1) of its members as chairman, appoint a Secretary who may or may not be a Benefit Committee member, and advise the Claims Administrator of such action in writing. The secretary shall keep a record of all meetings and forward necessary communications to the Employer or the Claims Administrator. The Benefit Committee may adopt such by-laws and regulations as it deems desirable for the conduct of its affairs. All decisions of the Benefit Committee shall be made by a vote of the majority including actions in writing taken without a meeting. A dissenting Benefit Committee member who, within a reasonable time after he has knowledge of any action or failure to act by the majority, registers his dissent in writing and delivers it to the other Benefit Committee members, the Employer and the Claims Administrator shall not be responsible for any such action or failure to act.

7.9 **Authorization of Claims Processing.** The Employer hereby authorizes the Claims Administrator to process claims in accordance with the provisions of the Plan.

7.10 **Application and Forms for Benefits.** The Benefit Committee may require an Employee to complete and file with the Benefit Committee an application for any benefit hereunder and any other forms required by the Benefit Committee, and to furnish all pertinent information requested by the Benefit Committee. The Benefit Committee may rely upon all such information so furnished it, including the Employee's current mailing address.

7.11 **Indemnification of the Benefit Committee.** The Benefit Committee and the individual members thereof shall be indemnified by the Employer against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

7.12 **Claims Administrator.** Processes claims, Precertifies benefits, provides certain financial services, provides reports and makes initial benefit determinations subject to the Plan and the direction of the Benefit Committee. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses.

ARTICLE VIII

MISCELLANEOUS

8.1 **Non-Guarantee of Employment.** Nothing contained in the Plan shall be construed as a contract of employment between the Employer and any Employee, or as the right of any Employee to be continued in the employment of the Employer or as limitation of the right of Employer to discharge any of its Employees with or without cause.

8.2 **No Rights to Assets of Employer or Plan Assets.** No Participant shall have any right to, or interest in, any assets of the Employer, or if applicable, any assets of the Plan upon termination of his employment or otherwise. All payments of benefits as provided for in the Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable, therefore, in any manner.

8.3 **Non-Alienation of Benefits.** Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

8.4 **Right of Reimbursement.** This section applies when the Participant has recovered damages, by verdict, judgement, settlement or otherwise, for an Injury or Sickness (including an occupational Injury or Sickness) caused by a third party. If the Participant has made, or in the future may make, such a recovery, including a recovery under a first-party automobile coverage, the Plan will not cover either the reasonable value of the services to treat such an Injury or Sickness or the treatment of such an Injury or Sickness.

However, if the Plan pays for or provides benefits for such an Injury or Sickness, the Participant shall promptly, when the recovery is received, reimburse the Plan from the monies recovered under the judgement, settlement or otherwise when the recovery is received for the amount the Plan has been fully reimbursed for benefits it paid for or provided benefits for said Injury or Sickness. Reimbursement shall be made regardless of whether the Participant has been made whole or fully reimbursed by the third party for his damages and regardless of any classification of such recovered proceeds as medical expenses or otherwise.

The Plan is a lien in the proceeds of any such recovery. The Participant shall sign and deliver, at the Plan's request, any documents needed to protect this lien. This lien shall remain in effect until the Plan is repaid in full.

The Participant shall cooperate with the Plan, including signing and delivering any documents the Plan reasonably requests to protect its rights of reimbursement, providing any relevant information, and taking such actions as the Plan may otherwise request in order to recover the full amount of benefits provided. The Participant shall not reduce the Plan's right of reimbursement.

These rights provide the Plan with a priority over any funds paid by a third party to a

Participant relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney's fees, or other costs and expenses.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing.

8.5 **Subrogation.** This section applies when another party is, or may be considered, liable for a Participant's Injury or Sickness (including an Occupational Injury or Sickness) and the Plan has provided or paid for benefits.

To the extent of the benefits provided by the Plan, the Plan is subrogated to all of the Participant's rights against any party (including any first party automobile coverage) or for the payment for the medical treatment of such Injury or Sickness. The Plan may assert this right independently of the Participant. The Plan shall be subrogated to such rights of the Participant regardless of whether the Participant has been made whole or fully reimbursed by the third party for his damages and regardless of any classification of such recovered proceeds as medical expenses.

The Participant is obligated to cooperate with the Plan in order to protect the Plan's subrogation rights. Such cooperation shall include providing the Plan with any relevant information, signing and delivering such documents as the Plan reasonably requests to secure its subrogation claim, and obtaining the Plan's consent before releasing any party from liability for payment of medical expenses. The Participant assigns to the Plan the Participant's rights and benefits under any insurance coverage, whether liability or no-fault, to the extent of the Plan's subrogation claims under this section.

If the Participant enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the recovery rights of the Plan under this section.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Participant in matters related to subrogation shall be borne solely by the Participant.

8.6 **Medicaid Assignment of Rights and Reimbursement.** Payment of benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of the Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993). Provided further that to the extent that payment has been made under such state plan in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment of benefits under the Plan will be made in accordance with any state law.

8.7 **Recovery of Overpayment.** When an overpayment has been made by Wells Fargo Third Party Administrators, Inc., Wells Fargo Third Party Administrators, Inc. will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

ARTICLE IX

AMENDMENTS AND ACTION BY THE EMPLOYER

9.1 **Amendments.** The Employer, by action of its Board of Directors at a meeting duly called and held or by written agreement, reserves the right at any time to make any amendment or amendments, to the Plan at its sole discretion by a signed written document. The Employer will inform all Participants of any amendment modifying the substantive terms of the Plan not later than two hundred ten (210) days after the close of the Plan Year in which the amendment was adopted; provided however, that if the amendment is a material reduction in covered services or benefits, the Participants will be notified not later than sixty (60) days after the date of adoption of the amendment.

9.2 **Action by the Employer.** Any action by the Employer acting by its Board of Directors under this Plan may be by any person or persons duly authorized by resolution of said Board of Directors to take such action.

ARTICLE X

SUCCESSOR EMPLOYER AND MERGER OR CONSOLIDATION OF PLANS

10.1 **Successor Employer.** In the event of the dissolution, merger, consolidation or reorganization of the Employer, provision may be made by which the Plan will be continued by the successor, and, in that event, such successor shall be substituted for the Employer under the Plan. The substitution of the successor shall constitute an assumption of Plan liabilities by the successor and the successor shall have all the powers, duties and responsibilities of the Employer under the Plan.

ARTICLE XI

PLAN TERMINATION

11.1 **Right to Terminate.** The Employer, by action of its Board of Directors at a meeting duly called and held or by written agreement, may terminate the Plan in whole or in part at any time in its sole discretion.

11.2 **Liquidation of the Plan Assets.** Upon termination of the Plan, the Plan assets (if any) shall continue until the Employer has paid all proper pending claims for benefits outstanding as of the date of termination and the remaining balance shall be liquidated and paid over to the employer's corporate assets, unless otherwise determined by the appropriate body of the employer.

ARTICLE XII

DEFINITIONS

Where the following defined terms are used throughout this document, they are capitalized for ease of reference.

Alcoholism Treatment Facility. An institution that mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism. It must make charges and meet applicable licensing standards. It prepares and maintains a written treatment plan on each patient based on medical, psychological and social needs which must be supervised by a Physician. The institution must provide the following twenty-four (24) hours a day:

- A. Detoxification services;
- B. Infirmary level medical services required for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the alcoholism and arrangement of Hospital level medical services, if needed;
- C. Supervision by a staff of Physicians; and
- D. Skilled nursing care by licensed nurses who are supervised by a Registered Graduate Nurse.

Ambulatory Surgical Facility. A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing Surgery and which fully meets one (1) of the following two (2) tests:

- A. It is licensed as an Ambulatory Surgical Facility by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; and
- B. Where licensing is not required, it meets all of the following requirements:
 1. It is operated under the supervision of a Physician who is devoting full time to supervision and permits Surgery to be performed only by a duly qualified Physician who, at the time the Surgery is performed, is privileged to perform the Surgery in at least one (1) Hospital in the area;
 2. It requires in all cases, except those requiring only local infiltration Anesthesia, that a licensed anesthesiologist administer the Anesthesia or supervise an anesthetist who is administering the Anesthesia and that the anesthesiologist or anesthetist remain present throughout the Surgery;
 3. It provides at least one (1) operating room and at least one (1) post-Anesthesia recovery room;
 4. It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services;
 5. It has trained personnel and necessary equipment to handle emergency situations;
 6. It has immediate access to a blood bank or blood supplies;
 7. It provides the full-time services of one (1) or more Registered Graduate Nurses for patient care in the operating room and in the post-Anesthesia recovery room; and
 8. It maintains an adequate medical record for each patient, the record contains an admitting diagnosis including, for all patients except those undergoing a procedure under local Anesthesia, a preoperative examination report, medical

history and laboratory test and/or X-rays, an operative report and a discharge summary.

Ancillary Charge. A charge for services and supplies required for the care and treatment of Sickness or Injury, other than Room and Board Charges, fees for professional services, or charges for nursing care or personal items such as television, telephone, laundry, barber or beauty services, etc.

Anesthesia.

Local - The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

General - The condition produced by the administration of specific agents to render the patient completely unconscious.

Benefit Committee. The Committee appointed pursuant to the Plan.

Birthing Center. A specialized facility which is primarily a place for delivery of a Child following a normal uncomplicated Pregnancy and which fully meets one (1) of the following two (2) tests:

- A. It is licensed by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; or
- B. If there is no state licensing requirement for such facilities, it meets all of the following requirements:
 - 1. It is operated and equipped in accordance with any applicable state law;
 - 2. It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
 - 3. It has available to handle foreseeable emergencies trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
 - 4. It is operated under the full-time supervision of a Physician or Registered Graduate Nurse;
 - 5. It maintains a written agreement with at least one (1) Hospital in the area for immediate acceptance of patients who develop complications; and
 - 6. It maintains an adequate medical record for each patient, containing prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.

Calendar Year. January 1st through December 31st.

Child. The term "Child" for purposes of this Plan, shall include any Child of a participating Employee or participating Retired Employee who falls within one (1) of the following categories:

- A. Any step-Child;
- B. Any legally adopted Child including any Child Placed for Adoption while the adoption proceedings are pending;
- C. Any foster Child;
- D. Any natural Child; and

- E. Any Child covered under a Qualified Medical Child Support Order issued to a participating Employee or Retired Employee or his Spouse.

Claims Administrator. The entity who processes claims, precertifies benefits, provides certain financial services, provides reports and makes initial benefit determinations subject to the Plan and the direction of the Benefit Committee. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses. For purposes of this Plan, this entity is Wells Fargo Third Party Administrators, Inc.

COBRA Continuation Provision. Any of the following: (a) Part 6 of subtitle B of Title I of ERISA; (b) section 4980B of the Internal Revenue Code of 1986, other than subsection (f)(1) of such section insofar as it relates to pediatric vaccines; (c) Title XXII of the Public Health Service Act.

Copayment. The portion of a Provider's Usual, Customary and Reasonable Charge or other negotiated fee that is the Participant's financial responsibility, pursuant to Article III not including any Deductibles.

Cosmetic Surgery. Surgery that is not the result of an Injury or congenital anomaly and is not Medically Necessary, but is for the sake of appearance.

Covered Medical Expenses. The Usual, Customary and Reasonable Charges incurred by or on behalf of a Participant for those covered expenses set forth in Article III. Such expenses are covered only:

- A. If they are incurred after the Participant commences participation in the Plan; and
- B. The extent that the services or supplies provided to the Participant are recommended by a Physician for Medically Necessary care of any non-Occupational Sickness or Injury.

Covered Service. An item, treatment, procedure, admission or medication that is Medically Necessary and appropriate for the diagnosis as set forth in the Plan.

Creditable Coverage. (a) A Group Health Plan; (b) Health Insurance Coverage; (c) Part A or Part B of the Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, (Medicaid) other than coverage consisting solely of benefits under Section 1928 of such Act; (e) Chapter 55 of Title 10, United States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under Chapter 89 of Title 5 (Federal employees), United States Code; (i) a public health plan, as defined in regulations issued under ERISA; (j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). The term Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 706(c) of ERISA.

Custodial Care. Services and supplies that:

- A. Are furnished mainly to train or assist the patient in personal hygiene and other activities of daily living, rather than to provide therapeutic treatment; and
- B. Can safely and adequately be provided by persons without the technical skills of a Provider.

Such care is custodial regardless of who recommends, provides and directs it, where it is

given and whether or not the patient can be or is being trained to provide self-care.

Deductible. The designated amount of Covered Medical Expenses to be paid by the Participant each Calendar Year before such Covered Medical Expenses become subject to consideration as Plan benefits. Designated Deductible amounts are set forth in Article III for Covered Medical Expenses.

Dependent. This term includes:

- A. The Spouse of an Employee or Retired Employee; and
- B. Any unmarried Child of an Employee or Retired Employee who:
 - 1. Is not yet 19 years old; or
 - 2. Is 19, but is not yet 26 and who attends a secondary school, college or university on a regular full-time basis, as defined by the school, college or university, as his or her principal activity.
When the Child reaches either limiting age, coverage will end on the date of the Child's birthday.
 - 3. Is beyond age 19 and who:
 - a. Is incapable of self-support because of mental or physical handicap; and
 - b. Became incapable of self-support before age 19 or while covered as a Dependent under this or any other group plan. Proof of the Child's incapacity may be required when a claim is first made after the Child attains age 19.
 - 4. Is included under a Qualified Medical Child Support Order issued to a participating Employee or Retired Employee or his Spouse.

Durable Medical Equipment. Equipment which is:

- A. Able to withstand repeated use;
- B. Primarily and customarily used to serve a medical purpose; and
- C. Not generally useful to a person in the absence of Sickness or Injury.

Employee. The term "Employee" for purposes of this Plan includes:

- A. An individual employed by the Employer who works twenty (20) regularly scheduled hours with the Employee having to pay 50% of the premium; thirty (30) regularly scheduled hours with the Employees having to pay 25% of the premium; and forty (40) regularly scheduled hours with the Employee premium being non-contributory ; or
- B. An individual employed or contracted by the Employer whose conditions of employment or contract performance require coverage under the benefit Plan; or
- C. An individual employed by the Employer and who is taking an unpaid leave pursuant to the Family and Medical Leave Act.

Employee Contribution. The amount, if any, specified from time to time by the Employer that a participating Employee or Retired Employee is required to contribute to this Plan in order for such Employee or Retired Employee and, if applicable, his Dependent(s) to participate in the Plan.

Employer. City of Goldsboro, or its successor or successors.

Enrollment Date. The date of enrollment in the Plan, or if earlier, the first day of the

Waiting Period for such enrollment.

ERISA. The Employee Retirement Income Security Act (ERISA) of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any Section of ERISA shall include any successor provision(s) thereto.

Experimental/Investigative. The use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet recognized by the Plan as acceptable medical practice as determined within the sole discretion of the Benefit Committee. This term will also apply if the services or supplies require Federal or other governmental agency approval and that approval was not granted at the time the services were received.

For purposes of the Plan, any treatment, procedure, facility, equipment, drugs, devices or supplies shall be experimental/investigative if: (a) not widely accepted throughout the Participant's geographic area by Physician Providers practicing in such geographic area as being safe, effective and appropriate for the Injury or Sickness; or (b) used for research or investigational use; or (c) conducted as part of a research protocol; or (d) not proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies; or (e) not approved by the Food and Drug Administration or other applicable governmental agency for general use at the time received if such approval was required to lawfully provide the drug or device; or (f) approved for a specific medical condition by the Food and Drug Administration or other applicable governmental agency but applied to another Sickness, Injury or conditions for which approval was required and not obtained at the time the drug, device, medical procedure or treatment was provided.

Extended Care Facility. A lawfully operated institution or that part of such an institution which assists patients in reaching the degree of body functioning necessary to permit self-care in essential daily living activities and:

- A. Is primarily engaged in providing, under the supervision of a Physician and on a full-time Inpatient basis, care and treatment of five (5) or more persons convalescing from Injury or Sickness;
- B. Provides twenty-four (24) hour-a-day professional nursing services supervised by a Registered Graduate Nurse regularly on duty within the premises;
- C. Maintains a daily clinical record of each patient; and
- D. Is not, except incidentally, a place for the aged, the treatment of drug or alcohol dependency, nor a place for custodial or educational care.

Family and Medical Leave Act. The Family and Medical Leave Act (FMLA) of 1993, as it may be amended from time to time, together with its related rules and regulations. References to any Section of the Family and Medical Leave Act shall include any successor provision(s) thereto.

Full-Time Student. Full-Time Student is defined by the school the student attends and varies according to quarter hours or semester hours, length of terms, and other school specific standards. When the Claims Administrator requests student status verification, enrollment and full-time status will be verified against the school's standards.

Group Health Plan. An employee welfare benefit plan as defined in Section 3(1) of ERISA to the extent that such plan provides for Medical Care to Employees or their Dependents through insurance, reimbursement or otherwise.

Health Insurance Coverage. Protection that provides payment of benefits for covered Sickness or Injury.

Health Insurance Issuer. An insurance company, insurance service or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance within the meaning of Section 514(b)(2) of ERISA. Such term does not include a Group Health Plan.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, August 21, 1996.

Home Health Care. The care and treatment of Sickness or Injury by a Home Health Care Provider.

Home Health Care Agency. An agency or organization that specializes in providing skilled nursing services and other therapeutic services and is providing Medical Care and treatment in the home. Such an agency or organization must meet all of the following requirements:

- A. It is primarily engaged in providing skilled nursing services and other therapeutic services and is licensed by the Community Health Accreditation Program (CHAP) to provide such services;
- B. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Graduate Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Graduate Nurse;
- C. It has a full-time administrator; and
- D. It maintains a complete medical record on each patient.

Hospice Care Agency. An agency or organization that offers a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for persons suffering from a condition that has a terminal prognosis. Such organization must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Graduate Nurse, and it must maintain centralized clinical records on all patients. It must meet the standards of the National Hospice Organization (NHO) and any applicable state licensing requirements.

Hospital. An institution which:

- A. Provides Medical Care and treatment of sick and Injured persons on an Inpatient basis;
- B. Does so at the patient's expense;
- C. Maintains facilities for surgical and medical diagnosis and treatment by or under the supervision of a staff of Physicians;
- D. Provides twenty-four (24) hour-a-day nursing service by or under the supervision of a Registered Graduate Nurse;

- E. Provides lab and X-ray services twenty-four (24) hours a day;
- F. Operates continuously with organized facilities for Surgery; and
- G. Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations.

Injury. All injuries received by a Participant in any one (1) accident.

Inpatient. Services requiring occupying a hospital bed, crib, or bassinet while under observation, care, diagnosis or treatment for at least twenty-four hours.

Intensive Care Unit. A separate and distinct part of a Hospital reserved for critically and seriously ill patients requiring highly skilled nursing care and close, frequent, if not constant, audiovisual observation and which provides for such patients the following:

- A. Room and Board;
- B. Nursing care by nurses whose duties are confined to the care of patients in such unit; and
- C. Specialized equipment and supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Late Enrollee. A Participant who enrolls under the Plan other than during (a) the first period in which the individual is eligible to enroll under the Plan or (b) the special enrollment period set forth in Section 4.3.

Medical Care. (a) The diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (b) amounts paid for transportation primarily for and essential to Medical Care referred to in subparagraph (a) of this Section; and (c) amounts paid for insurance covering Medical Care referred to in subparagraph (a) and (b) of this Section.

Medically Necessary Care (or Medical Necessity or Medically Necessary). Medically Necessary Care and treatment that is recommended or approved by a Physician or Dentist; is consistent with the patient's condition, symptoms, diagnosis or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare. The program of Medical Care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Part A means Medicare's Hospital Plan and Part B means Medicare's Voluntary Hospital Supplemental Medical Plan.

Mental Disorder Treatment Facility. An agency or organization that provides a program for diagnosis, evaluation and effective treatment of Mental/Nervous Disorders. It is not a school, custodial, recreational or training institution. It provides infirmity-level medical services required

for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the Mental/Nervous Disorder and arranges Hospital services if needed. It has at least one (1) Psychiatrist present during the entire treatment day. It provides the services of a psychiatric social worker and a psychiatric nurse twenty-four (24) hours a day. It prepares and maintains a written treatment plan for each patient which must be supervised by a Psychiatrist. The treatment plan is based on a diagnostic assessment of the patient's medical, psychological and social needs. Such agency or organization must meet all applicable licensing requirements for facilities providing such services.

Mental/Nervous Disorders. Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Mental Health Care or Treatment. Services directed to the effective treatment of the emotional and mental well-being of the individual, including electroshock therapy administered by a Physician and Anesthesia for the same. Marital, family and financial counseling are not Covered Medical Expenses.

Nurse Midwife/Practitioner. A person who is certified to practice as a nurse midwife in the state in which the services are performed and who fulfills both of the following requirements:

- A. A person licensed by a board of nursing as a Registered Graduate Nurse; and
- B. A person who has completed a program approved by the state in which the person is licensed as required in subparagraph A of this Section for the preparation of Nurse Midwives/Practitioner.

Occupational Sickness or Injury. An Occupational Sickness or Injury is any Sickness or Injury that is related to any work that is performed for pay or profit.

Open Enrollment Period. The period elected by the Plan Administrator during which an eligible Employee may elect to participate in the Plan, or a Participating Employee may elect to revoke a prior election to participate in the Plan, choose to be covered by another Group Health Plan offered by the Employer (if any) or to add or eliminate coverage of Dependents.

Oral Surgery. The branch of dentistry concerned with operative procedures in and about the oral cavity and jaw area.

Other Provider. A person or entity, other than a Hospital or Physician, which is duly licensed to render covered services.

Outpatient Pre-Admission Testing. Tests performed on a patient before confinement as an Inpatient provided the following requirements are met:

- A. The tests are related to the performance of scheduled Surgery;
- B. The tests have been ordered by a Physician after a condition requiring Surgery has been diagnosed and Hospital admission for Surgery has been requested by the Physician and confirmed by the Hospital; and
- C. The patient is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the patient's condition which precludes the Surgery.

Out-of-Pocket Limit. The Out-of-Pocket Limit is the designated limit on the amount of Covered Medical Expenses paid by a Participant during a Calendar Year including Deductibles. Specific Out-of-Pocket Limit amounts are set forth in the Schedule of Benefits. If the Out-of-Pocket limit is met during a Calendar Year, the Plan shall then pay 100% of Covered Medical Expenses incurred during the remainder of a Calendar Year.

The Out-of-Pocket Limit shall not apply to charges in excess of a Provider's Usual, Customary and Reasonable Charge nor charges exceeding the Calendar Year limits, or any lifetime limits as set forth in the Schedule of Benefits or those expenses specifically listed as excluded in the Plan.

Partial Hospitalization. A level of treatment where the patient spends a certain number of hours at the facility each day and returns to their home at night. Usually for more acute patients than day Hospital programs, but less acute than Inpatient or residential programs.

Participant. An Employee, Retired Employee or Dependent participating in the Plan in accordance with the eligibility provisions of the Plan.

Physician. A licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform Surgery. It will also include any other licensed medical practitioner if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a Physician.

Placed for Adoption or Placement of Adoption. The assumption and retention of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child.

Plan. The City of Goldsboro Medical Care Plan.

Plan Administrator. City of Goldsboro.

Plan Effective Date. July 1, 2000, the date on which the provisions of this Plan are effective. The effective date of the Plan as amended and restated is September 1, 2007.

Plan Sponsor. City of Goldsboro.

Plan Year. The Plan's fiscal year, the twelve (12) month period beginning on July 1 and ending on June 30.

Preauthorization. A request made prior to a procedure to verify benefits and medical appropriateness of the procedure. This allows the patient to make an informed decision of potential coverage for the procedure in advance. Preauthorization is not a guarantee of payment.

Precertification. A procedure to validate the Medical Necessity of a planned Hospital admission, emergency admission, surgical procedure or outpatient diagnostic service as required by the Plan. Clinical information is obtained and reviewed against established medical criteria to validate the Medical Necessity of the event and assign a length of stay for coverage purposes as appropriate. Precertification is not a guarantee of payment.

Pre-Existing Condition. An Injury or Sickness or any related condition present before the

Enrollment Date, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the Enrollment Date; provided, however, genetic information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to such information.

Prescription Drugs. The following will be considered Prescription Drugs:

- A. Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution -- Federal law prohibits dispensing without prescription".);
- B. Drugs which require a prescription under state law but not under federal law;
- C. Compound drug. (This is a drug that has more than one (1) ingredient. At least one (1) of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under state law.); and
- D. Injectable insulin.

Provider. A Hospital, Physician, or Other Provider, duly licensed and performing within the scope of any applicable license.

Psychiatrist. A Physician who specializes in psychiatry and has the needed training and experience to diagnose and treat Mental/Nervous Disorders.

Qualified Medical Child Support Order. A medical child support order meeting the requirements set forth in Section 609 of ERISA.

Retired Employee. City of Goldsboro Employees age 55 or older who retire from the City of Goldsboro with twenty (20) or more years of actual service and receive payments from the North Carolina Local Governmental Employee's Retirement System or from the Law Officer's Benefit and Retirement Fund as a result of such retirement are eligible for continued coverage under the City of Goldsboro's Group Health Insurance Plan. Employees who retire after thirty (30) years of actual service with the City of Goldsboro may continue coverage regardless of age.

Room and Board Charges. Those charges made by a Hospital or institutional Provider for room and board services.

Semi-Private Room Rate. The Room and Board Charges which a Hospital or Provider applies to most beds in its semi-private rooms with two (2) or more beds.

Sickness. An illness or disease. For purposes of this Plan, the term Sickness will include pregnancy.

Social Service Worker One who helps the elderly, disabled, ill and mentally disabled persons live in their own homes or in residential care facilities instead of in health facilities. Most personal and home care aides work with elderly or physically or mentally disabled clients who need more extensive personal and home care than family or friends can provide.

Social Worker A professional trained to talk with people and their families about emotional or physical needs and to find them support services.

Spouse. The lawful husband or wife of a participating Employee or Retired Employee who

is not legally separated from such Employee or Retired Employee. This does not include common law Spouses.

Substance Abuse Treatment Facility. An institution providing a structured twenty-four (24) hour-a-day Inpatient program for diagnosis, evaluation and effective treatment of alcoholism, and/or drug use or abuse; provides detoxification services; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Graduate Nurse; prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards applicable to facilities providing such services.

Surgery. The treatment of the body by operation or manipulation. It is not limited to cutting the body but includes manipulation such as the setting of broken bones or relocating dislocated joints (sometimes called “closed surgery”), and also includes dental surgery.

Surgical Opinion. A written opinion by a qualified Physician as to whether or not to perform Surgery. The opinion is given after an examination of the Participant and X-ray and laboratory work are completed. It must take place before the proposed Surgery is to be done. A **second surgical opinion** is the process of seeking an evaluation by another doctor or surgeon to confirm the diagnosis and treatment plan of a primary Physician, or to offer an alternative diagnosis and/or treatment approach.

Temporomandibular Joint (TMJ) Syndrome. Abnormal functioning of the temporomandibular joint which is the connecting hinge mechanism between the base of the skull (temporal bone) and the lower jaw (mandible).

Usual, Customary & Reasonable Charges, Fees & Expenses (UCR). A “usual” fee is the fee that a Provider most frequently charges for a specific procedure. A “customary” fee is the fee level determined by the administrator of a benefit plan from actual fees submitted for a specific procedure. This fee establishes the maximum benefit payable for that procedure. A “reasonable” fee is the fee charged by a Provider for a specific dental procedure that has been modified by complications or unusual circumstances.

Waiting Period. The period that must pass before an individual who is a potential Participant is eligible to participate in the Plan.

ARTICLE XIII

GENERAL PLAN INFORMATION

Plan Name:

City of Goldsboro Medical Care Plan

Plan Sponsor:

City of Goldsboro
214 North Center Street
Goldsboro, NC 27533

Agent for Service of Legal Process:

City of Goldsboro
214 North Center Street
Goldsboro, NC 27533

Employer Identification Number:

56-6000228

Plan Number:

501

Type of Plan:

Medical Care Plan

Plan Year Ends:

June 30

Funding:

Plan Benefits provided by:
City of Goldsboro
214 North Center Street
Goldsboro, NC 27533

The level of any Employee Contribution is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee Contributions. The Employer pays Plan benefits and administration expenses directly from general assets. Contributions received from eligible Participants are used to cover Plan costs and are expended immediately.

Plan Administrator:

City of Goldsboro
214 North Center Street
Goldsboro, NC 27533

General Plan Information (Continued)

Claims Administered By:

Wells Fargo Third Party Administrators, Inc.
P.O. Box 3262
602 Virginia Street, East
Charleston, WV 25332

Type of Plan Administration:

Self Administered

Source of Plan Contributions:

Contributions for Plan expenses are obtained from the Employer and from the Employee, and, if applicable, his Dependent(s). The Employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Employer and the amount to be contributed by the Employees.

ARTICLE XIV

APPLICATION OF STATE LAW

SUBJECT TO THE PROVISIONS OF ERISA, this Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of North Carolina and in courts situated in that state.

IN WITNESS WHEREOF, the Employer has caused its name to be signed by its proper officer thereunto duly authorized to evidence the adoption of this Plan on the ____ day of _____, 2007.

CITY OF GOLDSBORO

By _____

Its _____

RECEIPT FOR
MEDICAL
SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT

I have received my copy of the City of Goldsboro Medical Summary Plan Description and Plan Document. I understand that this document is intended only as a general guide to the Company's Medical Care Plan and that it in no way is to be considered an agreement or contract of employment. I understand that plan provisions and providers are subject to change at the company's discretion. I agree to read and keep my plan summary and any supplements or amendments that may be provided to me in the future.

SIGNED: _____

DATE: _____

DEPARTMENT: _____