

CITY OF FARMINGTON NEW MEXICO

(herein called the Plan Sponsor)

SUMMARY PLAN DESCRIPTION

OF

**MEDICAL CARE, DENTAL CARE, VISION CARE, AND
OUTPATIENT PRESCRIPTION DRUG BENEFITS**

FOR EMPLOYEES AND DEPENDENTS

Revised: October 1, 2008

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INTRODUCTION

The Healthcare Portability and Accountability Act and the Mental Health Parity Act provide conditions that may have a negative effect on the City of Farmington Group Health Plan. These acts provide that non-Federal governmental plans may opt out of any or all of the conditions of the acts. Because of the possible negative effects, the City of Farmington Group Health Plan has elected to opt out of certain provisions of the acts.

The acts provide for limitations on pre-existing conditions, requirements for special enrollment periods, prohibitions against individuals and beneficiaries based on health status and parity in the application of certain limits to mental health benefits. The City of Farmington Group Health Plan has elected to exempt itself from these requirements.

Your Employer has chosen the Benefits described in this Document for many reasons. The most important of these are to protect its most valuable assets -- its healthy and productive employees -- and to provide You (and Your family) with significant financial protection against the physical, emotional and economic strain Illness or Injury can bring.

Please read this document carefully to familiarize Yourself with the Benefits it describes and the procedures for filing claims. If You have any questions about Your coverage, please contact the plan representative.

When used in the Plan, unless otherwise stated, the terms are as defined in:

1. the General Definitions section, or
2. the specific benefits sections.

ELIGIBILITY

Eligible Employees

You are in an Eligible Class for coverage under the Plan if You are an employee and have begun work on a Full-Time Basis for Your Employer. Eligible employees do not include work performed by temporary or part-time employees (except for City Council Members and the Mayor).

You will be eligible for coverage under the Plan on the date You enter an Eligible Class, or the Effective Date of the Plan, if later.

Eligible Dependents

To be eligible for Dependent Coverage under the Plan, Your dependent(s) must be eligible.

Your Eligible Dependents are:

1. Your lawful spouse;
2. Your unmarried dependent Child less than age 25;
3. Your unmarried Child age 19 or older who is incapable of self-sustaining employment by reason of mental or physical handicap, who is chiefly dependent upon You for support and maintenance, and who has been continuously covered by the Plan prior to age 19 or 25, respectively. You must furnish proof of incapacity and dependency to the Plan Administrator within 31 days prior to the Child's 19th or 25th birthday and at reasonable intervals thereafter.

"Child" means: Your natural Child; Your stepchild; an adopted Child; a Child who has been Placed for Adoption with You; a Child for whom You have been appointed legal guardian; or a Child who is recognized under a qualified medical child support order as having a right to enrollment under the Plan (hereafter "QMCSO-child"). In all cases the Child must depend upon You for his/her main support and care. However, when a court recognizes a Child as a QMCSO-child, the Child will be considered Your Eligible Dependent regardless of whether the Child is living with You or receiving his/her main support and care from You.

No person may be covered as a dependent of more than one employee. An employee may not be covered as a dependent. With respect to a husband and wife, who are Eligible Employees, both spouses may Enroll for Employee coverage but only one spouse may Enroll for dependent coverage for eligible Children. If a parent and Child are both employed by the Employer and are both eligible for coverage as an Employee, both shall be covered as Employees and the Child shall not be covered as a Dependent of the parent.

If You elect Dependent Health Coverage, You must Enroll all Eligible Dependents.

The term "spouse" shall not include a common-law spouse.

ELIGIBILITY - Continued

Modification of Coverage for Newborns - Well and Sick Baby Care

When charges for delivery are considered a covered expense for an expectant mother eligible for coverage under this plan, any and all charges incurred by the newborn under the Well Baby Care provision as shown above are to be considered as charges incurred by the mother. Charges incurred by the newborn under the Sick Baby Care provision as shown above are to be considered as charges incurred by the mother for the first 6 days only. Charges incurred for inpatient days beyond 6 days are to be considered incurred by the Child.

Coverage for Newborns - Well Baby Care

A newborn Child will be covered from the moment of birth provided You already have Dependent Child(ren) Coverage or You have made arrangements to Enroll the newborn Child for coverage prior to the birth of the newborn Child. Such newborn Child will be eligible for the following Covered Expenses: a) Hospital room and board (or nursery) charges; b) routine Doctor visits while Hospital confined; and c) circumcision while Hospital confined.

This coverage will end on the earlier of:

1. the date the newborn Child is discharged or
2. the date the newborn Child is 7 days old.

Coverage for Newborns - Sick Baby Care

A newborn Child is covered from the moment of birth for Covered Expenses due directly to:

1. Injury or Illness;
2. premature birth; or
3. a condition which exists at birth.

If You do not have Dependent Coverage in force, this coverage (including any Extended Benefits) will end 31 days after the date Your Child is born. If You Enroll the Child within this 31 day period and make the required retroactive Contributions, coverage on the Child may continue.

WHEN COVERAGE BEGINS

For Eligible Employees:

If You are performing Active Work on a Full-Time Basis, coverage will be made effective on the first day of the calendar month that falls on or next follows 60 days from your date of hire if You Enroll on or before that date.

If You do not Enroll on or before that date, please refer to the provision on Late Enrollees within this section.

For Eligible Dependents:

Dependent Coverage cannot become effective prior to the date Your coverage is effective. Dependent Coverage will be effective with respect to each Eligible Dependent You then have on the first day of the calendar month that falls on or next follows 60 days from your date of hire:

If You do not Enroll Your dependents on or before that date, please refer to the provision on Late Enrollees below.

Enrollment Process:

Employees enroll themselves and their dependents, if applicable, for coverage by filing a written enrollment application with the Insurance & Benefits Division. The enrollment application must be on forms provided by the City of Farmington Group Health Plan. All enrollment applications must be filed with the Insurance & Benefits Division during the appropriate enrollment period as defined under the definition section.

Late Enrollees

If You do not Enroll within the 60 day waiting period, You are a Late Enrollee.

If You do not Enroll Your dependents within the 60 day waiting period or Your dependent was not enrolled within 31 days after he/she became eligible, Your dependent is a Late Enrollee.

If You wish to restore Your or a Dependent's Health Care Coverage which ended because You did not make required Contributions, You or Your dependent are considered Late Enrollees.

Persons previously denied coverage under the Plan who desire to apply again for coverage are considered Late Enrollees (including those persons who have voluntarily dropped coverage and desire to re-enroll).

A Late Enrollee is required to provide, at his/her own expense, proof of good health. A Late Enrollee's coverage will be made effective on the first day of the calendar month that falls on or next follows the date We approve such proof and will be subject to the Pre-Existing Conditions Limitations provisions. If approval is not given, the applicant will not be covered under the Plan.

WHEN COVERAGE BEGINS - Continued

When a person is eligible for coverage under the Plan and would normally be considered a Late Enrollee, the requirement of proof of good health shall be waived if application for coverage is made within 31 days of the occurrence of one or more of the events listed in the Special Enrollment Periods provision that have caused the involuntary loss of Health Care coverage for such person.

Special Enrollment Periods

The Special Enrollment Periods exist under the following circumstances:

1. Loss of Other Coverage. If You or an Eligible Dependent
 - a. was covered under another group health plan (including COBRA continuation) or had other medical insurance coverage at the time enrollment was declined; and
 - b. has lost or will lose coverage under the other plan as a result of loss of eligibility (due to such reasons as termination of employment, change of employment status, death of a spouse, divorce, legal separation or cessation of the employer's contributions to such coverage) or have exhausted COBRA continuation coverage,

You or an Eligible Dependent may Enroll within 31 days after loss of coverage. Coverage will be effective on the first day of the month following enrollment.

2. Acquisition of Dependents. If You did not Enroll when first eligible and acquire a dependent through marriage, birth, adoption or Placement For Adoption, You and the newly acquired dependent(s) may Enroll within 31 days of the date of marriage, birth, adoption or Placement For Adoption. In the case of the birth, adoption or placement of a Child, Your spouse may also be enrolled as Your dependent if otherwise eligible for coverage. Coverage will be effective on the date of birth, adoption or Placement For Adoption. In the case of marriage, coverage will be made effective on the first day of the month following enrollment.

The Plan's Pre-Existing Conditions Limitations requirements will apply to persons enrolled under these circumstances.

Additional Dependents

Dependent Coverage may be extended to any of Your new dependent(s) provided You have at least one dependent covered under the Plan. Such coverage will become effective on the date each new dependent becomes eligible.

WHEN COVERAGE ENDS

For Employees:

Your coverage will end on the date of the first of these events:

1. If You are covered as an Active Employee, the end of the month in which You stop Active Work on a Full-Time Basis in an Eligible Class, except that:
 - a. if You stop Active Work due to Injury, Illness or Qualified Leave of Absence for personal Injury or Illness, Your Employer will continue Your Health coverage subject to payment of Contributions. Such coverage will continue only while You are unable to return to work because of the Injury, Illness or Qualified Leave of Absence. This coverage continuance will be on a basis precluding individual selection;
 - b. if You stop Active Work to take a qualified military leave of absence (pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994) You may elect to continue coverage subject to payment of Contributions. Such coverage will continue only while You are unable to return to work because of the qualified military leave of absence. Such continuance will be on a basis precluding individual selection;
 - c. if You stop Active Work to take a Qualified Leave of Absence (pursuant to the Family and Medical Leave Act of 1993 or other applicable state's leave law, if any such law applies to Your Employer), for reasons other than personal Illness or Injury, Your Employer will continue coverage subject to payment of Contributions. Such coverage will continue only while You are unable to return to work because of the Qualified Leave of Absence. Such continuance will be on a basis precluding individual selection.

If coverage ends while You are on an approved family or medical leave of absence (as defined in the Family and Medical Leave Act of 1993), coverage for You and Your eligible dependents will be reinstated on the first day You return to active employment. The Pre-Existing Conditions Limitation and Waiting Periods will be waived. However, all accumulated annual and lifetime maximum will apply.
 - d. if You stop Active Work due to other leave of absence, Your Employer may elect to continue coverage subject to payment of Contributions. Such coverage may be continued to six months after such leave took place. This coverage continuance will be on a basis precluding individual selection.
2. You stop making Contributions, if required.
3. As to any one coverage or class, the date the Plan is amended or changed to exclude that coverage or class.
4. The Plan ends.

For Dependents:

A dependent's coverage will end on the earlier of:

1. the date Your coverage ends; or
2. the end of the month in which the dependent ceases to be eligible as defined by the Plan.

MEDICARE

This section applies to a Covered Person who is eligible for Medicare coverage. It provides rules for determining the order of benefit payments between coverage under this Plan and those of Medicare. The intent of this section is to conform the Plan to the requirements of the federal Medicare Secondary Payer law. Accordingly, the section and its stated rules will be adjusted, if We deem necessary, so that the Plan's liability for Benefit payment is neither greater nor less than those required under the law.

1. If, pursuant to the rules:
 - a. this Plan is determined to be secondary to Medicare, it will pay secondary to and coordinate its Benefits with Medicare;
 - b. this Plan is determined to be primary to Medicare, it will pay Benefits without regard to Medicare benefits.
2. The order of benefit payments rules are outlined below.

a. Rules applicable to a person covered under the Plan by virtue of that person's "Current Employment Status" with an Employer or as a dependent of such person:

Basis of Medicare Eligibility:

This Plan Will:

- | | |
|--|---|
| - Old-Age (attaining age 65)* | Be primary. |
| - Disability (other than ESRD) | Be primary. |
| - End Stage Renal Disease (ESRD) | Be primary for the first 30 months of ESRD Medicare coverage; be secondary thereafter. |
| - Old-Age or Disability, preceding or beginning concurrently with ESRD | Continue to be primary until the end of the first 30 months of ESRD Medicare coverage; be secondary thereafter. |

*If a Covered Person elects to have Medicare as primary coverage, such person's Health Care coverage (including any Dental Care, Prescription Drug or Vision Care coverage), under this Plan will terminate. If the employee's Health Care coverage terminates in accordance with this provision, coverage on the employee's covered dependents will cease on the same date.

For purposes of this section, "Current Employment Status": a person is considered to have Current Employment Status with an Employer if the person is an employee, is the Employer (including self-employed person), or is associated with the Employer in a business relationship.

REMEMBER: The Medicare section outlined above applies from the date a Covered Person is first ELIGIBLE for Medicare (either part A or part B), whether or not the Covered Person is enrolled and is receiving Medicare benefits.

PRE-EXISTING CONDITIONS

You or Your Eligible Dependent has a "Pre-Existing Condition" if the Covered Person:

1. has consulted a Doctor or Dentist;
2. has taken prescribed medicine;
3. is receiving or has received health care;

for that condition in the three months before his/her Enrollment Date (as defined by the Plan).

Pregnancy, including Complications of Pregnancy, is not a Pre-existing Condition. Genetic information, in the absence of a diagnosis of a resulting condition, will not be considered a Pre-existing Condition.

Pre-Existing Conditions Limitations

Benefits will be limited to the first \$500 for a Pre-Existing Condition, until 12 consecutive months have elapsed from the Covered Person's Enrollment Date.

Waiver of Pre-Existing Conditions Limitations

The Pre-Existing Conditions Limitations provision is waived if You were covered under a group health plan of Your prior employer with no lapse of coverage more than 63 days, not including any Waiting Periods.

MEDICAL CARE BENEFITS

SCHEDULE

Important Notice

Your medical coverage includes one or more features to help control medical care costs. Some features will affect the amount of Benefits payable for Your medical care. See the Managed Health Care section of the Plan for a further explanation.

Three different levels of Benefits are being provided under the Plan:

1. The two "PCP Care and In-Network" benefit level will be payable for services rendered by a Participating Provider, and
2. The "Out-of-Network" benefit level will be payable for services rendered by a provider who is not a Participating Provider.

Employee and Dependent Coverage

**Amounts Applicable To
You or a Dependent**

Medical Care

Lifetime Maximum For all Covered Expenses \$2,000,000

Lifetime Maximum for Covered Expenses Incurred for:

- | | | |
|----|--|----------|
| 1. | All Treatment of Mental Health Conditions, Alcoholism and Drug Abuse (Combined) | \$25,000 |
| 2. | Organ Transplants Benefits: | |
| | - travel, lodging and meals for the recipient and one other person (up to \$150 per day) | \$10,000 |
| | - procurement services; and | \$10,000 |
| | - Private Duty Nursing services per eligible transplant | \$10,000 |
| | (For additional information, see Organ Transplant provision.) | |

Calendar Year Maximum for Covered Expenses Incurred for:

- | | | |
|----|--|------------|
| 1. | All Treatment of Mental Health Conditions, Alcoholism and Drug Abuse (Combined) | \$12,500 |
| 2. | Inpatient Treatment of Mental Health Conditions, Alcoholism and Drug Abuse (Combined) | 30 days |
| 3. | Outpatient Treatment of Mental Health Conditions, Alcoholism and Drug Abuse (Combined) | \$3,000 |
| 4. | Home Health Care and Private Duty Nursing Visits (Combined) | 100 visits |
| 5. | Chiropractic Care and Physical Therapy (Combined) | \$2,500 |

Calendar Year Deductible (with respect to employees with employee only coverage or employee coverage with one dependent)

(Applicable to Primary Plan)

	PCP Care	Out-of-Network
The Individual Deductible equals Covered Expenses in the amount of:	\$250	\$1,500
The Family Unit Deductible equals Covered Expenses in the amount of:	\$375	\$1,750

(Applicable to Regional Plan)

	In-Network	Out-of-Network
The Individual Deductible equals Covered Expenses in the amount of:	\$500	\$1,500
The Family Unit Deductible equals Covered Expenses in the amount of:	\$750	\$1,750

MEDICAL CARE BENEFITS - Continued

Calendar Year Deductible (with respect to employees with employee only coverage or employee coverage with two or more dependents)

(Applicable to Primary Plan)

	PCP Care	Out-of-Network
The Individual Deductible equals Covered Expenses in the amount of:	\$250	\$1,500
The Family Unit Deductible equals Covered Expenses in the amount of:	\$500	\$2,000

(Applicable to Regional Plan)

	In-Network	Out-of-Network
The Individual Deductible equals Covered Expenses in the amount of:	\$500	\$1,500
The Family Unit Deductible equals Covered Expenses in the amount of:	\$1,000	\$2,000

The Family Unit Deductible must be satisfied by You and Your Family Unit members who are covered as dependents. No part of any Covered Expenses for which Benefits are paid or payable by the Plan may be used to satisfy the Family Unit Deductible.

Services	The Plan Will Pay		Out-of-Network
	PCP Care/ In-Network Primary Plan	Regional Plan	
1. Charges of a Doctor for the treatment of an illness or injury:			
a. visits to the office or at a Covered Person's home (excludes visits for Mental Health Conditions, Alcoholism, Drug Abuse and dental care).	Deductible applies; payable at 100% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
b. Allergy injections, flu shots and other injections given in the office.	Deductible does not apply; payable at 100% after the Covered Person pays a \$10 Per Visit Fee.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
c. Surgery performed in the office.	Deductible applies; payable 100% after the Covered Person pays a \$50 Per Visit Fee.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
d. All other covered services performed in the office including surgery.	Deductible applies; payable at 100% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.

MEDICAL CARE BENEFITS - Continued

Services	The Plan Will Pay		Out-of-Network
	PCP Care/ In-Network		
	Primary Plan	Regional Plan	
e. Surgery performed on an outpatient or inpatient basis at a Hospital.	Deductible applies; payable at 90% after the Covered Person pays a \$50 Copayment Per Visit.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
f. Inpatient Hospital services.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
2. Charges incurred for treatment at an Urgent Care Facility.	Deductible applies; payable at 90% after the Covered Person pays a \$35/\$20** Copayment Per Visit. **Select Provider	Deductible applies; payable at 80% after the Covered Person pays a \$40 Copayment Per Visit.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Copayment Per Visit.
3. All charges (Doctor and Facility) for treatment of a Mental Health Condition, Alcoholism and Drug Abuse.	Deductible does not apply; payable at 80%.	Deductible does not apply; payable at 80%.	Deductible does not apply; payable at 80%.
4. Charges performed by a private duty nurse.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
5. Charges incurred for durable medical equipment.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
6. Hospital charges for emergency room care*.	Deductible applies; payable at 90% after the Covered Person pays a \$100 Copayment per visit.	Deductible applies; payable at 80% after the Covered Person pays a \$100 Copayment per visit.	Deductible applies; payable at 60% after the Covered Person pays a \$100 Copayment per visit.
7. Charges incurred for services of a radiologist, pathologist, anesthesiologist or emergency room Physician.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
8. Charges incurred for authorized Home Health Care.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
9. Charges incurred for authorized Hospice Care.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
10. Hospital daily room and board charges.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.

MEDICAL CARE BENEFITS - Continued

Services	The Plan Will Pay		Out-of-Network
	PCP Care/ In-Network		
	Primary Plan	Regional Plan	
11. Hospital charges for inpatient Hospital Confinement.	Deductible applies; payable at 90% after the Covered Person pays a \$300 Copayment Per Confinement.	Deductible applies; payable at 80% after the Covered Person pays a \$500 Copayment Per Confinement.	Deductible applies; payable at 60% after the Covered Person pays a \$1,500 Copayment Per Confinement.
12. Outpatient Hospital charges for a cutting surgical procedure performed at a Hospital, licensed ambulatory surgical center or a lawfully operating Birthing Center (includes all related expenses except surgeon charges).	Deductible applies; payable at 90% after the Covered Person pays a \$200 Copayment Per Confinement.	Deductible applies; payable at 80% after the Covered Person pays a \$200 Copayment Per Confinement.	Deductible applies; payable at 60% after the Covered Person pays a \$200 Copayment Per Confinement.
13. Ambulance charges for:			
a. ground transportation; (Copayment waived if admitted)	Deductible applies; payable at 90% after the Covered Person pays a \$50 Copayment.	Deductible applies; payable at 90% after the Covered Person pays a \$50 Copayment.	Deductible applies; payable at 90% after the Covered Person pays a \$50 Copayment.
b. air transportation.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%	Deductible applies; payable at 60%
14. Preventive Care:			
a. charges incurred for examinations, immunizations, boosters and tests;	No Deductible applies; payable at 100% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
b. routine vision examinations;	No Deductible applies; payable at 100% after the Covered Person pays a \$15 Per Visit Fee.	No Deductible applies; payable at 100% after the Covered Person pays a \$15 Per Visit Fee.	No Deductible applies; payable at 100% after the Covered Person pays a \$15 Per Visit Fee.
c. lab work done in connection with a preventive care service.	No Deductible applies; payable at 100%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
15. Charges incurred for a CAT scan or MRI.	Deductible applies; payable at 90% after the Covered Person pays a \$100 Copayment.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.

MEDICAL CARE BENEFITS - Continued

Services	The Plan Will Pay		Out-of-Network
	PCP Care/ In-Network		
	Primary Plan	Regional Plan	
16. Charges incurred for outpatient diagnostic x-ray and lab work.	Deductible applies; payable at 90% after the Covered Person pays a \$50 Copayment for x-rays and/or a \$10 Copayment for lab work.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
17. Charges incurred at a Skilled Nursing Facility.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
18. Charges incurred for pregnancy:			
a. hospitalization;	Deductible applies; payable at 90% after the Covered Person pays a \$300* Copayment Per Pregnancy.	Deductible applies; payable at 80% after the Covered Person pays a \$300** Copayment Per Pregnancy.	Deductible applies; payable at 60% after the Covered Person pays a \$300*** Copayment Per Pregnancy.
	*The \$300 Copayment for San Juan IPA will increase to \$400 if the pre-natal care is not received during the first trimester.		
	**The \$300 Copayment for the Regional Plan will increase to \$1,000 if the pre-natal care is not received during the first trimester.		
	***The \$300 Copayment for the Non-PPO will increase to \$4,000 if the pre-natal care is not received during the first trimester.		
b. Doctor charges for maternity delivery.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.
19. Charges for Chiropractic Care.	Deductible applies; payable at 90% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
20. Charges incurred for Physical Therapy.	Deductible applies; payable at 90% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
21. Charges incurred for Occupational Therapy and Speech Therapy.	Deductible applies; payable at 90% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
22. Charges incurred for Chemotherapy.	Deductible applies; payable at 90% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
23. Charges incurred for Organ Transplants	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.

MEDICAL CARE BENEFITS - Continued

Services	The Plan Will Pay		Out-of-Network
	PCP Care/ In-Network		
	Primary Plan	Regional Plan	
24. Charges incurred for Cardiac Rehabilitation.	Deductible applies; payable at 90% after the Covered Person pays a \$25 Per Visit Fee.	Deductible applies; payable at 80% after the Covered Person pays a \$40 Per Visit Fee.	Deductible applies; payable at 60% after the Covered Person pays a \$50 Per Visit Fee.
25. Charges incurred for pain management if billed by:			
a. a Doctor's office;	Deductible applies; payable at 100% after the Covered Person pays a \$100 Copayment.	Deductible applies; payable at 80% after the Covered Person pays a \$100 Copayment.	Deductible applies; payable at 60% after the Covered Person pays a \$100 Copayment.
b. a Surgery Center.	Deductible applies; payable at 90% after the Covered Person pays a \$200 Copayment.	Deductible applies; payable at 90% after the Covered Person pays a \$200 Copayment.	Deductible applies; payable at 90% after the Covered Person pays a \$200 Copayment.
26. All other Covered Expenses.	Deductible applies; payable at 90%.	Deductible applies; payable at 80%.	Deductible applies; payable at 60%.

"Per Visit Fee," "Copayment Per Visit," "Copayment Per Confinement" and "Copayment Per Pregnancy" mean that portion of Covered Expenses You are required to pay out of Your pocket before The Plan Will Pay Benefits for any remaining portion.

You will not be reimbursed for any Copayment Per Visit, Copayment Per Confinement or Copayment Per Pregnancy nor do they apply toward any Deductible or Out-of-Pocket Amount.

You will not be reimbursed for any Per Visit Fee nor will such Per Visit Fee apply toward any Deductible or Out-of-Pocket Amount.

MEDICAL CARE BENEFITS - Continued

Out-of-Pocket Expense Maximum (with respect to employees with employee only coverage or employee coverage with one dependent)

Applicable to Primary Plan:

	PCP Care	Out-of-Network
Individual Amount	\$1,250	\$5,500
Family Amount	\$1,850	\$9,750

Applicable to Regional Plan:

	In-Network	Out-of-Network
Individual Amount	\$2,000	\$5,500
Family Amount	\$2,250	\$9,750

Out-of-Pocket Expense Maximum (with respect to employees with employee only coverage or employee coverage with two or more dependents)

Applicable to Primary Plan:

	PCP Care	Out-of-Network
Individual Amount	\$1,250	\$5,500
Family Amount	\$2,500	\$14,000

Applicable to Regional Plan:

	In-Network	Out-of-Network
Individual Amount	\$2,000	\$5,500
Family Amount	\$4,000	\$14,000

Selecting a PCP:

You will be asked to select a Participating Provider as your Primary Care Provider ("PCP") during your enrollment with the Primary Plan. Your PCP can be a Participating Provider ("In-Network") who is a Family Practice, Internal Medicine, General Practice or Pediatric Provider. A participant may always self-refer to a Participating OB/GYN for obstetrical or gynecological care without prior authorization from San Juan IPA or the PCP.

To obtain In-Network Health Care Services, you should contact your selected PCP or San Juan IPA. Your PCP or the San Juan IPA will provide, or refer you to a health care Provider who can provide you with the appropriate Health Care Services.

Your San Juan IPA identification card acts as your key to access the system. You should always show the Health Care Services Provider your San Juan IPA identification card. It includes information that will be helpful to you and your Provider. Only the name of the employee's chosen PCP will appear on the cards issued for family coverage.

Any Health Care Services you receive from someone other than a Participating Provider will be covered under the Out-of-Network benefit, unless the service qualifies as an Emergency Health Care Service or San Juan IPA has specifically authorized the service.

MEDICAL CARE BENEFITS - Continued

When Out-of-Pocket Expenses have been paid by one Covered Person during a calendar year, the applicable co-insurance level of Benefit payments for PCP/In-Network services will automatically increase to 100% for any additional eligible Covered Expenses incurred by that same person during the remainder of that calendar year.

When Out-of-Pocket Expenses have been paid by one Covered Person during a calendar year, the applicable co-insurance level of Benefit payments for Out-of-Network services will automatically increase to 100% for any additional eligible Covered Expenses incurred by that same person during the remainder of that calendar year.

When Out-of-Pocket Expenses have been paid on behalf of all the covered members of Your Family Unit during a calendar year, the applicable co-insurance level of Benefit payments for PCP/In-Network services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by any covered family member during the remainder of that calendar year.

When Out-of-Pocket Expenses have been paid on behalf of all the covered members of Your Family Unit during a calendar year, the applicable co-insurance level of Benefit payments for Out-of Network services will automatically increase to 100% for any additional eligible Covered Expenses Incurred by any covered family member during the remainder of that calendar year.

An "Out-of-Pocket Expense" is the 10%, 20% and 40% shares of any otherwise eligible (Reasonable and Customary) expense which You pay. Copayments, Per Visit Fees, Hospital Deductibles Per Confinement, Pre-Treatment Authorization Penalties, Concurrent Review Penalties and Deductibles are not considered eligible Out-of-Pocket Expenses.

These increases will not apply to charges incurred for the treatment of Mental Health Conditions, Alcoholism and Drug Abuse.

The following items do not count toward the Out-of Pocket Maximum:

- A. All applicable medical co-payments;
- B. Prescription drug co-payment s or expenses incurred that are part of the prescription drug benefit;
- C. The amount of any reduction in payment for eligible charges due to failure to obtain pre-authorization;
- D. Expenses incurred for services when a benefit limit, if applicable has been reached;
- E. Charges/payments for treatment of Mental and Nervous Disorders, Chemical Dependency and Substance Abuse;
- F. Expenses incurred to the extent that the billed amount exceeds the eligible charges(this amount is not the responsibility of the member as long as the covered service were rendered by a participating provider);
- G. Ineligible expenses.

Room and Board Maximum

- 1. Private room accommodation
- 2. Ward or semiprivate accommodation
- 3. Intensive care accommodation

Average Semiprivate Room Charge
the Covered Expense Incurred
three times the Hospital's Average
Semiprivate Room Charge

MEDICAL CARE BENEFITS - Continued

Skilled Nursing Facility Benefit

Maximum Covered Expense

- | | | |
|----|-----------------|--|
| 1. | Daily Benefit | One-third of the Average Semiprivate Room charge of the last Hospital in which the Covered Person was confined prior to confinement in the Skilled Nursing Facility. |
| 2. | Maximum Benefit | 60 days per calendar year. |

* * * * *

Medical Care Benefits

When Injury or Illness causes You or Your dependent, while covered under this Plan, to incur Covered Medical Care Expenses, the Plan will determine Benefits according to the Schedule and the limitations and exclusions outlined in the Plan. Benefits for each Covered Expense will be calculated as follows:

1. The Reasonable and Customary fee will be determined.
2. The amount will be reduced by any applicable Co-payment.
3. The amount will be reduced by any applicable Deductible.
4. The remaining amount will be multiplied by the appropriate Covered Percentage, resulting in the Benefit payable.
5. The Benefit payable will be subject to the maximums shown on the Schedule.

Deductible Requirement

Your or Your dependent's Deductible Requirement will be met when the Covered medical Expenses Incurred while covered during each calendar year equal the Deductible Amount shown on the Schedule. You are required to pay this amount, the Plan will not reimburse You for this expense.

The following special Deductible provision is included to help You and Your covered dependents meet this Deductible Requirement.

Family Unit Deductible: The Family Unit Deductible Requirement will be met when all Covered Expenses applied to individual Deductibles for covered members of Your family, in a calendar year, equal the Family Unit Deductible shown on the Schedule.

Primary care directed referrals, patient choice and availability and location of specialty care will impact on patient co-payment and deductibles.

Annual deductibles are included in annual out of pocket maximums.

Co-payments are independently accrued by each plan option utilized by participant.

Deductible and coinsurance are cumulative by plan option.

MEDICAL CARE BENEFITS - Continued

Covered Expenses

The Plan Will Pay Benefits as shown on the Schedule for the following Medical Care expenses of a Covered Person if the expenses are considered Covered Expenses as defined in General Definitions:

1. Hospital daily room and board, general nursing care, and intensive care, to the Maximum Amounts shown on the Schedule.
2. All other Medically Necessary miscellaneous services and supplies furnished by a Hospital during covered Inpatient Hospital Confinement, but not for private duty nursing care.
3. Pre-admission testing performed within 14 days of a scheduled Inpatient Hospital Confinement.
4. Outpatient Hospital charges for medical care and supplies used on the premises of a Hospital.
5. Medically Necessary services and supplies furnished in a licensed Ambulatory Surgical Center.
6. Medically Necessary services and supplies furnished in a lawfully operating Birthing Center.
7. Skilled Nursing Facility charges for:
 - a. daily room and board up to the maximum of 60 days per calendar year;
 - b. a confinement beginning within 30 days of discharge from an Inpatient Hospital Confinement of at least 3 days; or
 - c. a confinement that begins within 30 days of a prior Skilled Nursing Facility confinement. The confinement must be for the same Illness or Injury that caused the prior confinement.
8. Professional service charges of a Doctor (other than psychiatric/psychological service charges).
9. Professional psychiatric/psychological service and professional counseling charges of a Doctor or a licensed professional counselor for treatment of Mental Health Conditions, subject to the maximums shown on the Schedule.
10. Professional service charges of a Doctor for surgery.
11. Professional service charges of a Doctor for the giving of anesthesia.
12. Professional service charges made of a Doctor, or by a laboratory for diagnostic laboratory and x-ray exams.
13. Private duty nursing charges for services performed by an R.N. or L.P.N. when You or Your dependent is not Hospital-or Skilled Nursing Facility-confined, subject to the maximum shown on the Schedule.
14. Physiotherapy services of a physiotherapist, subject to the maximum shown on the Schedule.
15. Charges for services of a qualified speech therapist to correct speech loss or damage which:
 - a. follows surgery to correct a birth defect;
 - b. follows surgery due to Illness; or
 - c. is due to Illness, except a functional nervous disorder, congenital defect, delayed speech or other learning development conditions.
16. Charges for anesthesia when given by a Doctor.
17. Medical equipment as defined by the Plan.
18. Emergency transportation of a Covered Person to the nearest Hospital where care and treatment of the Illness or Injury can be given, or to another medical institution for special treatment that is not locally obtainable and is considered to be Medically Necessary.
19. Pap smears and routine mammographic screening as defined in the Preventive Care Benefit section.
20. Expenses for pregnancy will be payable as shown on the schedule for a female employee or covered dependent wife. No Benefits will be payable for expenses which relate to the pregnancy of a dependent Child.
21. Expenses Incurred for the treatment of Mental Health Conditions, Alcoholism and Drug Abuse as defined by the Plan.
22. Charges incurred for Preventive Care expenses as defined in the Preventive Care section.
23. Home Health Care as defined in the Home Health Care section.
24. Hospice Care as defined in the Hospice Care section.
25. Psychological testing; counseling or group therapy (except for marital, family or sexual dysfunction counseling).
26. Treatment of Temporomandibular Joint Dysfunction.

MEDICAL CARE BENEFITS - Continued

27. Organ Transplants as defined by the Plan, subject to the maximum shown on the Schedule.
28. Flu shots
29. Charges incurred for Norplant or an IUD.
30. Depo Provera shots and Medroxprogesteron shots.
31. Charges rendered by a certified family nurse practitioner or a certified nurse practitioner; and physician assistant.
32. Expenses Incurred for Medical Diets required control inborn errors of metabolism.
33. Expenses Incurred for Smoking Cessation benefits as defined by Superintendent's minimum coverage
34. Voluntary sterilization procedures, vasectomies, bilateral tubule ligation.
35. Colonoscopy for Men and women at high risk, with one of the following risk factors:
- A first-degree relative (sibling, parent, child) who has had colorectal cancer or an adenomatous polyp, screening should begin at age 40 **OR**
 - Family history of familial adenomatous polyposis (FAP) screening should begin at puberty:
 - Sigmoidoscopy annually, beginning at age 10 to 12
 - Colonoscopy every one to two years, beginning at age 20 to 25, or 10 years younger than the earliest case in the family, whichever comes first.
 - Personal history of adenomatous polyps:
 - One or more adenomatous polyps removed at the time of colonoscopy, screening should be managed according to the pathological findings
 - Numerous adenomas, a malignant adenoma (with invasive cancer), a large sessile adenoma, or an incomplete colonoscopy should have a short interval follow-up, based on pathological findings
 - Advanced or multiple adenomas (equal to or greater than three); first follow-up colonoscopy should occur in 2 years
 - One or two small (less than one centimeter) tubular adenomas; first follow-up colonoscopy should occur at 3 years
 - On-going surveillance after first follow-up colonoscopy; if the colonoscopy is normal or only one or two small (less than one centimeter) tubular adenomas are found, the next colonoscopy can be in five years
 - Personal history of colorectal cancer:
 - After colon resection, with curative intent, then approximately six months after the surgery, **OR**
 - Surveillance after colorectal cancer, if the colonoscopy performed at six months or a complete pre-operative examination is normal, subsequent colonoscopy should be repeated at three years and ten; if normal, every five years
 - Personal history of inflammatory bowel disease:
 - For surveillance,
 - Every one to two years after an eight year history of the disease with pancolitis **OR**
 - Every one to two years after 15 years history of left-sided colitis **OR**
 - For all patients beginning with eight to ten years of disease to document the extent of the disease.
36. Diabetic education provided by a certified diabetic educator or licensed dietitian.

If any of the preceding Covered Expenses are incurred during a covered Inpatient Hospital Confinement or as a covered outpatient Hospital charge, they will be paid as covered Hospital charges or outpatient Hospital charges, as the Plan determines appropriate, and not as a separate Benefit.

MEDICAL CARE EXCLUSIONS AND LIMITATIONS

Your Employer has chosen to provide many Benefits. There are some things, however, that will not be covered as Medical Care Benefits. These are:

1. Charges not included as Covered Expenses.
2. Blood or plasma when a refund or credit is made for those items.
3. Cosmetic or plastic surgery and related charges, unless due to:
 - a. an accidental Injury; or
 - b. a birth defect;and which interferes with a normal function of the body or causes physical pain.
4. Hearing aids and their fitting.
5. Eyeglasses or contact lenses and the fitting of such (except the first pair after cataract surgery, and for conditions related to the genetic error of inborn metabolism).
6. Eye refractions.
7. Care or supplies furnished due to:
 - a. an act of war (declared or undeclared);
 - b. insurrection or Riot.
8. Care or supplies which are furnished by a facility operated for or by the U.S. Government (or its agency) or by a Doctor employed by that place unless:
 - a. for Emergency treatment when You or Your dependent must pay for those services;
 - b. for non-service connected disabilities in a Veterans Administration Hospital;
 - c. incurred by a U.S. military retiree (covered by this Plan) and his/her covered dependents, while confined in a military medical facility.
9. Care and services to the extent furnished or payable under:
 - a. a plan or program operated by a National Government or one of its agencies;
 - b. a state cash sickness or similar law.
10. Care and supplies for which:
 - a. no charge is made;
 - b. You or Your dependent would not have to pay if You did not have this coverage.
11. Intentionally self-inflicted Injury.
12. Injury or Illness resulting from taking part in the commission of an assault or felony.
13. Injury or Illness arising out of employment, whether or not You or Your dependent is covered by Worker's Compensation or similar laws.
14. Exercise for the eyes (orthoptics).
15. Nerve stimulators.
16. Services or supplies for obesity, weight reduction or dietary control, including treatment of morbid obesity.
17. The following types of care:
 - a. Custodial Care, except as provided in the Home Health Care Benefit;
 - b. care to assist the patient in the activities of daily living;
 - c. maintenance care, not expected to improve the patient's medical condition.
18. Charges incurred by other than the diagnosed patient.
19. Treatment of teeth or nerves connected to teeth, except:
 - a. unerupted teeth (impacted teeth);
 - b. treatment of an accidental Injury to natural teeth; or
 - c. covered Hospital charges (as defined) when needed for dental care.
20. Any service rendered by a Close Relative or someone having the same legal residence as the patient.
21. Expenses which relate to the pregnancy of a dependent Child.

MEDICAL CARE EXCLUSIONS AND LIMITATIONS - Continued

22. In-vitro fertilization, artificial insemination, infertility treatment, and all related expenses (except necessary care and supplies needed to diagnose infertility), family planning or contraceptive services (other than those listed in the list of Covered Expenses).
23. Reversal of an elective sterilization procedure.
24. Surgical correction of eye refraction which can be corrected by eyeglasses or lenses (radial keratotomy, keratectomy, keratoplasty).
25. Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
26. Education or training of any type for the treatment of learning disabilities and attention deficit disorders; I.Q. testing.
27. Thermograms, temperature gradient studies.
28. Any care or supplies received prior to the Effective Date or after the Termination Date of this coverage (unless coverage is continued according to some Plan provision).
29. Any service rendered by a person who is not legally qualified to perform that service.
30. Sex transformations and hormones related to such.
31. Elective induced abortion, unless carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performing of an abortion, any Covered Expenses incurred to treat those complications will be considered under this Plan; but the initial costs relating to the abortion will not be covered.
32. Charges incurred for acupuncture.
33. Charges incurred for bariatric surgery for morbid obesity, except when medical management criteria is met.

MEDICAL CARE BENEFIT PROVISIONS

Conditions and Maximums for Treatment of Mental Health Conditions, Alcoholism and Drug Abuse (Combined)

The Plan Will Pay Benefits for the treatment of a Mental Health Condition, Alcoholism and Drug Abuse up to the following maximums:

1. \$25,000 Lifetime Maximum;
2. \$12,500 Calendar Year Maximum for all treatment while confined in a Hospital; and
3. \$3,000 Calendar Year Maximum for all outpatient treatment.

For Plan purposes, a "Mental Health Condition" means any of the following conditions or diagnosis; schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, manic-depressive illness), anxiety disorders, somatoform disorders, personality disorders, autism and other disorders of infancy, childhood and adolescence and all other diagnoses as presented in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders as published by the American Psychiatric Association, **including such disorders which are biologically or organically based or due to biochemical imbalances.**

Special Requirements for Mental Health Conditions, Alcoholism and Drug Abuse

You must contact Mines & Associates at (800) 873-7138 to receive a referral to another provider or before receiving any treatment for a Mental Health Condition, Alcoholism or Drug Abuse. If admission is on an emergency basis, you must call within two working days. Failure to comply with these requirements will result in reduced benefits.

Full Course of Care:

Inpatient Benefits for treatment of Alcoholism and/or Drug Abuse will not be provided unless the Hospital certifies to the Contract Administrator that the Covered Person has completed the full course of prescribed, inpatient care.

Minimum 48-Hour Requirement:

Inpatient Benefits for the treatment of Alcoholism and/or Drug Abuse will not be provided for admissions of less than 48 hours.

Medical Equipment

The Plan Will Pay for medical equipment (including orthopedic and prosthetic devices) which can withstand repeated use, is not disposable, is prescribed by a Doctor only when Medically Necessary, is appropriate for use in the home, and is not useful in the absence of an Illness or Injury, including but not limited to the following:

1. man-made limbs or eyes to replace natural limbs or eyes;
2. casts, orthopedic splints or crutches;
3. trusses or braces needed because of:
 - a. an injury or illness;
 - b. a disabling condition existing since birth;
4. oxygen;
5. rental of equipment for giving oxygen or to aid in breathing if the equipment has a mouthpiece, hose and compressor;
6. temporary rental of wheelchairs, hospital beds, walkers or commode chairs and the purchase of wheelchairs, hospital beds, walkers or commode chairs if the patient's condition requires an indefinite, prolonged period of use;
7. dialysis equipment rental, supplies, upkeep and training for You or Your dependents to use this equipment;

MEDICAL CARE BENEFIT PROVISIONS - Continued

8. ostomy bags;
9. glucometers, dextrometers, dextrostix, and rental of infusion pumps;
10. burn pressure garments or dressings; and
11. breast prostheses (as defined under the Post-Mastectomy Coverage provision) and initial post-mastectomy holding bra.

Benefits will also be provided for adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances and post mastectomy holding bra).

Specifically excluded from coverage are items such as support hosiery, bandages, diapers, formula, toilets, shower or bath equipment, air conditioners or air filters, exercise equipment, whirlpools, hot tubs, and splinting of teeth.

Covered Expenses for the rental of medical equipment will not exceed the purchase price for such equipment.

Post-Mastectomy Coverage

Coverage of a Medically Necessary mastectomy will also include coverage of the following:

1. physical complications during any stage of the mastectomy, including lymphedemas;
2. reconstruction of the breast;
3. surgery on the non-diseased breast to attain the appearance of symmetry between the two breasts; and
4. breast prostheses.

The Plan Will Pay Benefits on the same basis as for similar services. This coverage will be provided in consultation with the attending Physician and the Covered Person. Benefits are subject to the Pre-Treatment Authorization requirements of the Managed Health Care section.

Organ Transplants

The Plan Will Pay Benefits for Hospital and Doctors' services for the surgical removal of human organ or tissue from a living donor to a transplant recipient as follows:

1. when the transplant recipient and donor are both Enrolled for coverage under the Plan, Benefits for Covered Expenses will be provided for both patients under the recipient's coverage;
2. when only the transplant recipient is Enrolled for coverage under the Plan, Benefits for Covered Expenses will be provided for the recipient. Benefits may also be provided for the donor for Covered Expenses under the recipient's coverage, but only if those services are not eligible under any other coverage available to the donor;
3. when the donor is Enrolled for coverage under the Plan but the transplant recipient is not, Benefits for Covered Expenses rendered to the donor will not be provided. Benefits will not be provided for services rendered to the transplant recipient;

provided the transplant has been reviewed and approved by Us and the Utilization Management Organization.

The Plan Will also Pay Benefits for travel, lodging and meals for the recipient and one other person up to \$150 per day to a maximum lifetime Benefit of \$10,000.

Benefits for organ transplants are also limited to the following lifetime maximums:

1. \$10,000 for all procurement services; and
2. \$10,000 for all Private Duty Nursing services per eligible transplant.

MEDICAL CARE BENEFIT PROVISIONS - Continued

Preventive Care Benefits

Preventive medicine emphasizes treatment to avoid possible health problems as an alternative to postponing treatment until symptoms appear. The Plan includes Benefits to help You and Your covered dependents avoid future health problems by providing Benefits for care that can prevent Illness or detect it in its early stages. This can often result in more cost-effective treatment and make recovery from Illness more likely.

1. The Plan Will Pay Benefits at the level shown on the Schedule for physical examinations, immunizations, vaccinations, booster shots and the related office visit for Your Child(ren), subject to the following limits:

Under 1 Year of Age

- 1 physical exam prior to Hospital discharge. A series of 3 Prevnar
- 5 periodic physical exams by a Physician. A series of 2 Comvax of Hep B and HIB
- 1 blood test for phenylketonuria.
- 1 blood test for hypothyroidism.
- 1 phytonadione immunization.
- 1 tuberculosis skin test.
- 1 hematocrit/hemoglobin.
- A series of 3 polio vaccines.
- A series of 3 diphtheria, pertussis and tetanus (DPT).

1 Year to 6 Years

- 3 physical exams between age 1 and 2. The 4th in the series of Prevnar
- 2 immunization for measles, mumps and rubella (MMR). 1 physical exam age 2 until age 6 per year.
- 2 polio vaccines.
- 1 tuberculosis skin test.
- 1 hematocrit/hemoglobin.
- 1 urinalysis.
- 1 Hemophilus influenza type B (Hib) vaccination.
- A series of 2 diphtheria, pertussis and tetanus (DPT).

6 Years to 12 Years

- 1 tuberculosis skin test. 1 physical exam age 6 until age 12 per year.
- 1 urinalysis.

12 Years to 18 Years

- 1 diphtheria, tetanus booster if it is 10 years from previous booster.
- 1 tuberculosis skin test.
- 1 physical exam age 12 until age 18 per year.

2. The Plan Will Pay Benefits at the level shown on the Schedule for physical examinations (to include immunizations) for You, Your spouse or Your dependent Child age 18 and over, subject to the following limits:

18 years to 40 Years

- 1 urinalysis every 5 years.
- 1 hematocrit/hemoglobin every 5 years.
- 1 multi-chemical screen every 5 years.
- 1 single electrocardiogram (EKG) every 5 years.

For Women Age 18 and Older

- 1 breast and pelvic exam each year.
- 1 hematocrit each year.
- 1 urinalysis each year.
- 1 mammography and cytologic screening (pap smear) each year.

40 Years and Over

- 1 urinalysis every 2 years.
- 1 hematocrit/hemoglobin every 2 years.
- 1 multi-chemical screen every 2 years.
- 1 single electrocardiogram (EKG) every 2 years.
- 1 test of stool for occult blood every 2 years.
- 1 sigmoidoscopy every 5 years.

For Men Age 40 and Older

- 1 prostate PSA test per calendar year.

MEDICAL CARE BENEFIT PROVISIONS - Continued

3. The Plan Will Pay Benefits for covered services at 100%, not subject to the deductible or co-payments including nutrition counseling, testing and follow-up for an authorized diabetic program.

Home Health Care Benefits

If You or Your covered dependent is confined in a Hospital (and Benefits are payable under this Plan for the Hospital confinement), but:

1. the attending Physician certifies that the Covered Person could go home if certain medical services were provided there for continued care of the same Illness or Injury; and
2. the Physician provides a written plan for such home care, to be administered by a licensed Home Health Care Agency;

The Plan Will Pay Benefits at the level shown on the Schedule of all Covered Expenses (as defined in the Medical Care Benefits section) Incurred as part of the home care plan, except visits by a nurse (R.N., L.P.N. or L.V.N.) or home health aide are limited as shown on the Schedule.

Subject to any applicable Maximum Benefits and to Our retrospective review of the treatment plan, Home Health Care coverage will continue as long as the Covered Person's Physician continues to certify the need for such care.

If Benefits are paid for a Covered Expense under this provision, payment will not be made for that same expense under any other Plan provision.

Home Health Care Benefits are not payable for:

1. Custodial Care;
2. transportation service;
3. services of someone who lives with the patient;
4. services not included in the written home care plan of the Physician of record;
5. services rendered at a time when the patient is not under the care of the Physician who set up the home care plan;
6. any items excluded under the Medical Care Exclusions section of the Plan.

MEDICAL CARE BENEFIT PROVISIONS - Continued

Hospice Care Benefits

When Your or Your covered dependent's Physician recommends (in writing) on or before Hospice care is started a plan of Hospice care for:

1. palliative care of a terminal illness (where life expectancy is less than six months); and
2. You or Your dependent elects (in writing to Us) to follow the Physician's proposed treatment plan;

The Plan Will Pay Benefits at the level shown on the Schedule of all Covered Expenses (as defined in the Medical Care Benefits section) Incurred as part of the Hospice care plan for up to six months from the date it was established.

If Benefits are paid under this provision for any Covered Expense, payment for that same expense will not be duplicated under any other Plan provision. These Benefits are in lieu of any other Plan coverage for treatment related to the terminal illness while the Covered Person is confined in a Hospice. Coverage under this provision ends if You or Your dependent elects (in writing to Us) to discontinue Hospice care, or the Maximum Benefit has been paid.

Hospice Care Benefits are not payable for:

1. services provided by persons who do not regularly charge for their services;
2. counseling which is not provided as part of the Hospice care plan;
3. services provided by homemakers, caretakers and the like;
4. funeral expense;
5. treatment intended to cure the terminal illness.

MANAGED HEALTH CARE

READ THIS SECTION CAREFULLY
FAILURE TO USE THESE PROVISIONS MAY COST YOU MONEY

Pre-Treatment Authorization

All Inpatient Hospital Confinements, except for Emergency confinements, all surgical procedures that are performed outside of a Doctor's office, and certain outpatient Ambulatory Surgical Center/Hospital surgery must be reviewed and authorized PRIOR to admission or surgery in order to determine the Medical Necessity of care.

The Utilization Management Organization must be contacted as soon as Hospital confinement or a surgical procedure to be performed outside a Doctor's office is recommended. Emergency confinements and elective outpatient Ambulatory Surgical Center/Hospital surgery must be reported to the Utilization Management Organization within 48 hours of the Emergency admission. The telephone number for the Utilization Management Organization is shown on a Covered Person's health identification card. Benefits for the Hospital Confinement will be as shown on the Schedule.

The following surgical procedures require Pre-Treatment Authorization and may require a second surgical opinion.

Abdominal or Vaginal Hysterectomy	Dilation and curettage
Adenoidectomy	ERCP
Arthroscopy of the knee (surgical)	Elective Esophagogastroduodenoscopy
Bunionectomy	Hemorrhoidectomy
Cardiac Catheterization	Hip Arthroplasty (total)
Cardiac Pacemaker Insertion	Knee Arthroplasty (total)
Carotid Endarterectomy	Lithotripsy
Carpal Tunnel Release	Oophorectomy, Salpingectomy
Cataract Extraction	Salpingo-oophorectomy
Cholecystectomy (removal of gall bladder)	Septoplasty
Coronary Angiography	Trans Urethral Prostatectomy
Coronary Transluminal Angioplasty	Tonsillectomy and/or adenoidectomy
Cervical or Lumbar Spinal Fusion	Thyroidectomy
Cervical or Lumbar Laminectomy	Tympanostomy Tube Insertion
Cesarean Section (repeat)	Ulcer Surgery
Colonoscopy	Varicose Vein Excision and Ligation
Coronary Bypass	

Pre-Treatment Authorization of outpatient services is required for the following procedures/treatment.

In office procedures with the expected billed charges Greater than \$500 (excluding fracture care)	Prosthetics/Orthotics greater than \$500
All out- of network referrals	Non-emergency ground or air transportation
All outpatient surgeries; Sleep Apnea Studies	Pain Management (in-office)
Speech, physical and occupational therapy	MRI, MRA, CAT, PERT and PETT scans
Epidurals/Blocks/Pain Management procedures requiring outpatient facility	Durable medical equipment (all rental & purchases)
Cardiac cath or cardiac rehabilitation	Injectable medications obtained by the member (excluding insulin)
Hospice Care	Home Health Care and home IV infusions
Therapy that extends beyond 60 days	Carotid scans/doppler and venograms
Infusion chemotherapy	Treatment of Temporomandibular Joint Dysfunction
Diabetic nutritional counseling	UGI Endoscopy

The Utilization Management Organization will obtain all information, including pertinent clinical information, necessary to make a decision regarding authorization. Requests for information will be limited to those necessary to make a determination. If the Doctor or Hospital fails to provide the necessary information, the Utilization Management Organization will not be able to authorize the services and the penalties shown herein may be applied to a Covered Person's Benefits.

MANAGED HEALTH CARE - Continued

The Covered Person will be notified of the Utilization Management Organization's decision no later than 15 days after the day the Utilization Management Organization is contacted for the authorization request. If a decision cannot be made due to matters beyond the control of the Utilization Management Organization, the Covered Person will be notified as to the reason for the extension and the date by which a decision is anticipated. If additional information is needed from the Covered Person, the Covered Person will have at least 45 days to return the requested information. The Utilization Review Organization will render a decision no later than 15 days after the day the information is received, plus any days remaining from the original 15 day determination period provided the information is received within such period.

If the standard 15 day decision-making time would place the life or health of a Covered Person in serious jeopardy, the Covered Person's ability to regain maximum function would be jeopardized or, in the Doctor's opinion would subject the Covered Person to unmanageable pain, the request for pre-treatment authorization may be considered as urgent care. A Doctor may determine whether urgent care is involved. If a Doctor has not made that determination, the determination may be made by a representative of the Plan, applying the judgment of a prudent layperson possessing an average knowledge of health and medicine.

The Utilization Management Organization will make a determination on requests for Pre-Treatment Authorizations involving urgent care conditions no later than 72 hours after receipt of the request. If additional information is needed in order to make a determination, the Covered Person will be notified within 24 hours of receipt of the request and will have at least 48 hours to provide the necessary information. The Utilization Management Organization will inform the Covered Person of the decision no later than 48 hours after the end of the time period for providing the necessary information.

"Urgent Care" means that the standard 15 day decision-making time period would place the life or health of a Covered Person in serious jeopardy, the Covered Person's ability to regain maximum function would be jeopardized or, in the Doctor's opinion would subject the Covered Person to unmanageable pain. A Doctor may determine whether Urgent Care is involved. If a Doctor has not made that determination, the determination may be made by a representative of the Plan, applying the judgment of a prudent layperson possessing an average knowledge of health and medicine.

A Covered Person is responsible for contacting the Utilization Management Organization. If the Utilization Management Organization is not contacted, The Plan Will reduce Benefits by 10% for covered Hospital charges and/or surgeon's charges incurred as a result of a Hospital confinement and/or surgery.

If a Covered Person fails to comply with the Utilization Management Organization's determination, The Plan Will reduce Benefits by 10% for covered Hospital charges and/or surgeon's charges incurred as a result of such confinement and/or surgery.

If the Inpatient Hospital Confinement occurs for surgical treatment, only one penalty will be imposed.

Concurrent Review

In addition to having Hospital admissions authorized prior to admission, a Concurrent Review of treatment (again for Medical Necessity) will be conducted throughout the period of confinement. If additional days of confinement are requested beyond those initially authorized by the Utilization Management Organization, the Utilization Management Organization must be contacted to obtain authorization for the continued stay. If the request involves Urgent Care and is made to the Utilization Management Organization at least 24 hours before the end of the initially authorized days, the Covered Person will be notified within 24 hours as to whether the continued stay will be authorized. If the request is not made at least 24 hours before the end of the initially authorized days, the Urgent Care time periods described in the Pre-Treatment Authorization provision will apply.

If the request does not involve Urgent Care, the Covered Person will be notified of the Utilization Management Organization's decision no later than 15 days after the date the Utilization Management Organization is contacted for the authorization request. If a decision cannot be made due to matters beyond the control of the Utilization Management Organization, the Covered Person will be notified, within the initial 15 day decision period, of the reason for the extension and the date by which a decision is anticipated. If additional information is needed the Doctor or the Hospital will be notified within the initial 15 day decision period and will have at least 45 days from receipt of the notice to return the requested information. If the Covered Person, the Doctor or Hospital fails to provide the necessary information, the Utilization Management Organization will not be able to authorize the services and the penalties shown herein may be applied to a Covered Person's Benefits. If the information is received within the 45 days, the Utilization Management Organization will render a decision no later than 15 days after the date the information is received.

MANAGED HEALTH CARE - Continued

If, prior to the end of an authorized stay, the Utilization Management Organization finds the stay is no longer Medically Necessary, the Covered Person will be notified in advance that the stay will not be covered by the Plan.

A Covered Person is responsible for contacting the Utilization Management Organization. If the Utilization Management Organization is not contacted, The Plan Will reduce Benefits by 10%, for each day of unapproved confinement.

If the Covered Person fails to comply with the Utilization Management Organization's determination, The Plan Will reduce Benefits by 10% for each day of unapproved confinement.

"Concurrent Review" means the Utilization Management Organization will evaluate the medical need for continued hospitalization. This will involve consultation with the Covered Person's Doctor and comparison of clinical information to professionally developed medical standards of care.

Retrospective Review

The Utilization Management Organization will evaluate the medical record of those Covered Persons who were not reviewed under Pre-Treatment Authorization or Concurrent Review. If the Utilization Management Organization is unable to authorize any portion of the stay or treatment, the Doctor will be contacted to provide additional information. No Benefits will be paid for any days of the Hospital stay or treatment that would not have been authorized by the Utilization Management Organization. The decision concerning authorization will be made within 30 days after the claim that is the subject of the Retrospective Review is received. If additional information is needed, the Covered Person or his/her Doctor or Hospital will be notified within 30 days of receipt of the claim and will have at least 45 days from receipt of the notice to provide the information. If the information is received within 45 days, a decision will be made within 15 days of the day the Utilization Management Organization receives the additional information. If the additional information is not received within the 45 day period, the Covered Person should consider the claim, or portion thereof that is under review, to be denied. The claim will be reconsidered if the information is subsequently received. Written notice of the decision will be sent to the Covered Person.

"Retrospective Review" means the Utilization Management Organization will review the medical need for hospitalization or treatment after such hospitalization or treatment has taken place. This will involve consultation with the Covered Person's Doctor and comparison of clinical information to professionally developed medical standards of care.

Benefits For Services of a Participating Provider

The Plan provides different levels of Benefits depending on whether or not a Covered Person uses the services of a Participating Provider. **Generally**, Benefits will be payable at a higher level if services of a Participating Provider are used; although there may be additional Plan requirements. Participating Providers will submit claims on the Covered Person's behalf and will contact the Utilization Management Organization to obtain necessary approvals. Covered Persons may utilize the provider of their choice. If a Covered Person selects a Participating Provider, The Plan Will Pay Benefits, if any, to the provider of service.

If a Covered Person chooses not to use a Participating Provider, he/she may be responsible for filing his /her own claims and obtaining the proper Utilization Management approvals.

If Emergency Care is needed, a Covered Person should go to the nearest health facility. The Plan Will Pay Medical Care Benefits as shown on the Schedule.

MANAGED HEALTH CARE - Continued

Emergency Services

Emergency Care is covered for Emergency Medical Conditions (as defined in the General Definitions section). If You or Your dependent have has an Emergency Medical Condition, go directly to the nearest Hospital. Refer to the Pre-Treatment Authorization provision for information on contacting the Utilization Management Organization in the event of an Emergency Hospital admission. The Plan Will Pay Medical Benefits as shown on the Schedule.

Emergency Room Deductible

In addition to any other Deductible, a Copayment Per Visit as shown on the Schedule will be imposed before Benefits are payable for Covered Expenses Incurred during a visit to an emergency room of a Hospital.

This Copayment will not apply if the Covered Person is confined in the Hospital immediately after the visit.

Appeals Procedure

A Covered Person or his/her Doctor, or other Authorized Representative has the right to appeal an Adverse Determination. The address to which to send an appeal and any other contact information will be included with an Adverse Determination.

If a Covered Person or his/her Doctor or other Authorized Representative does not agree with an Adverse Determination, a Covered Person or his/her Doctor or other Authorized Representative may initiate the appeal by telephoning, faxing or submitting a written request to the Utilization Management Organization. Additional evidence may be presented for consideration on appeal. Initial appeal requests must be received within 180 days of the initial Adverse Determination.

“Authorized Representative” means the Covered Person’s spouse, parent, Doctor or Hospital. It will also include any other person who submits proof that he or she has been designated by the Covered Person or court of law to act on such person’s behalf.

“Adverse Determination” means that the Covered Person’s Hospital admission, continued hospital stay or other health care service has been reviewed and, based upon the information provided, does not meet the Utilization Management Organization’s requirements for being Medically Necessary, Appropriate, effective or in the proper setting and may result in noncoverage of the health care service.

Standard Appeal

In connection with Our review of the appeal, You have the right to 1) see the Plan and other relevant papers affecting the claim, 2) argue against the denial in writing, 3) have a representative act on Your behalf in the appeal. All comments, documents, records and other information submitted in connection with the claim being reviewed will be considered.

Within 15 days of receiving the appeal request, the Utilization Management Organization will notify the person who submitted the appeal of its decision in writing. The appeal will be reviewed by a Doctor who:

1. has appropriate training and experience in the field of medicine involved in the medical judgment;
2. was not previously involved with the Adverse Determination; and
3. is not the subordinate of the person previously involved with the Adverse Determination.

MANAGED HEALTH CARE - Continued

Expedited Appeal

If the Standard Appeal process would place the life or health of a Covered Person in serious jeopardy or the Covered Person's ability to regain maximum function would be jeopardized, a request for an expedited appeal may be phoned in by the Covered Person, a Doctor with knowledge of the Covered Person's medical condition or other Authorized Representative (if any). The Utilization Management Organization will conduct the review by telephone or through the exchange of written information. The Covered Person, his/her Authorized Representative (if any), and his/her Doctor will be informed of the decision by telephone or fax within 72 hours of the Utilization Management Organization's receipt of the appeal request.

The appeal will be reviewed by a Doctor who:

1. has appropriate training and experience in the field of medicine involved in the medical judgment;
2. was not previously involved with the Adverse Determination; and
3. is not the subordinate of the person previously involved with the Adverse Determination.

You may request information regarding voluntary appeals procedures.

Second Appeal

A Covered Person or his/her Doctor or other Authorized Representative may initiate a second appeal of the Adverse Determination by submitting a written request to the Utilization Management Organization within 60 days of the date of the Adverse Determination received as a result of an initial standard or expedited appeal.

An independent external reviewer will evaluate all relevant information and render a decision that will be binding on the Plan. The decision will be rendered within 15 days of the date the Utilization Management Organization receives the appeal request. A second Expedited Appeal will be considered a voluntary appeal. Decisions regarding a second Expedited Appeal will be rendered within a time frame appropriate to the medical condition of the patient. There are no other voluntary appeal rights available with respect to the Pre-Treatment Authorization, Concurrent Review or Retrospective Review for Medical Necessity.

You may request information regarding voluntary appeals procedures.

COORDINATION OF BENEFITS

If this is not Your only Health coverage, the Benefits payable under this Plan, and any other group plan for the Allowable Expenses Incurred during any Benefit Determination Period will be coordinated so that the combined Benefits paid or provided by all plans will not exceed 100% of such Allowable Expenses.

You must inform Us if You have other coverage (for example, through Your spouse's employer); and give Your consent to the release of information so that We may use this provision. You should first file Your claim with the primary plan (as determined below). When the claim is paid, send a copy of the charges and a copy of the Explanation of Benefits Statement from the first plan to the secondary plan (as determined below). This will accelerate the processing of Your claim.

One of Your Plans will be determined to be primary (using the rules below). The primary plan pays its full benefits first. The plan paying second takes the benefits of the primary plan into account when it determines its benefits.

A plan is primary when:

1. the plan does not have a COB provision;
2. the plan designates itself as an "excess" or "always secondary" plan; or
3. if both plans have a COB provision, under the rules it is determined to be primary.

When both plans have a COB provision, the order in which the plans provide benefits is determined using the first of the following rules which applies:

1. Employee/dependent. The plan which covers the person as an active employee is primary. If You or Your dependent is also covered by Medicare, the plan covering the person as an active employee is primary, the plan covering the person as a dependent of an active employee is secondary, and then Medicare.
2. Dependent children.
 - a. If the parents are not separated or divorced, the plan which covers the parent whose birthday (month and day) falls earlier in the calendar year is primary. If both parents have the same birthday (month and day), the plan which covered the parent longer is primary. If the other plan does not have the "birthday rule", the rule in the other plan will determine the primary plan.
 - b. If the parents are separated or divorced, the plan which covers the natural parent with custody is primary; followed by the plan which covers the step-parent who has married the natural parent with custody; and finally, the plan which covers the natural parent without custody.

However, if the court decrees one of the parents responsible for health care expenses, the plan which covers that parent is primary.

If the decree names the parent other than the natural parent with custody, We must be notified and have actual knowledge of those terms. Any Benefits paid prior to actual knowledge will not be affected. The plan of the other parent and the plan of the spouse of the parent with custody will be secondary and third, respectively.

If joint custody is granted by the court, the rules pertaining to parents who are not separated or divorced apply.

3. Active/inactive employee. The plan covering the employee who is neither laid off or retired is primary. If the other plan does not have this rule, this rule is ignored.

COORDINATION OF BENEFITS - Continued

4. Continuation coverage. Continuation coverage provided under either federal or state law is secondary. If the other plan does not have this rule, this rule is ignored.
5. Length of coverage. If the primary plan cannot be determined using any of the rules above, the plan which has covered the person for the longest period of time will be considered primary.

If this Plan is determined to be secondary, We will reduce Benefits payable so that the total benefits provided by all plans during a claim determination period are not more than the total Allowable Expenses for the Covered Person. We will use the amount by which We have reduced the Benefits to pay Allowable Expenses, not otherwise paid, which were Incurred during the claim determination period and have been submitted for that person.

The actual Benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Plan will never exceed the amount which would have been paid if there were no other plans involved. If Benefit payments under this Plan are reduced by COB, only the reduced amounts will be charged against Your Plan maximums.

If during Coordination of Benefits, payments are made in error, the plans will have the right to adjust payments among themselves. Such payments satisfy Our liability. If We overpay a claim, We will have the right to recover such overpayments from any person for, to whom, or with respect to whom such payments were made, any other insurance company, or any other organization.

Definitions

An "Allowable Expense" is the Reasonable and Customary amount for any necessary medical, dental, vision, or health care service which is covered (at least in part) by one of the plans. If a health plan provides services (rather than cash payments) a dollar value will be assigned in order to use this provision.

When the primary plan penalizes You for not complying with plan provisions, such as failing to pre-certify, the amount of the reduction is not considered an Allowable Expense.

A "Benefit Determination Period" means from January 1 of one year to December 31 of the same year.

A "plan" as used in this provision, is any of the following which provides health benefits or services:

1. a group or group blanket plan on an insured basis;
2. other plans which cover people as a group;
3. a self-insured or non-insured plan or other plan which is arranged through an employer, trustee or union;
4. a pre-payment plan which provides medical, vision, dental or health service;
5. government plans, except Medicaid;
6. group auto insurance, but only to the extent medical benefits are payable under group auto insurance;
7. no-fault auto insurance on an individual basis, except where not allowed by the state in which this Plan is issued;
8. single or family subscribed plans issued under a group or blanket type plan;

but the definition of plan shall not include:

1. hospital indemnity type plans;
2. school accident-type coverage.

PRESCRIPTION DRUG BENEFITS

SCHEDULE

Prescription Drug Expense Benefit

	Formulary Brand	Non-Formulary Brand	Generic
Copayment Amount for each purchase of injectable insulin:			
Participating Home Delivery Pharmacy	\$40.00	\$70.00	\$24.00
Participating Provider Pharmacy	20% of the Reasonable and Customary charge with a minimum Copayment of \$20.00	20% of the Reasonable and Customary charge with a minimum Copayment of \$35.00	20% of the Reasonable and Customary charge with a minimum Copayment of \$12.00
Copayment Amount for each purchase of any other Prescription or Prescription refill:			
Participating Home Delivery Pharmacy	\$40.00	\$70.00	\$24.00
Participating Provider Pharmacy	20% of the Reasonable and Customary charge with a minimum Copayment of \$20.00	20% of the Reasonable and Customary charge with a minimum Copayment of \$35.00	20% of the Reasonable and Customary charge with a minimum Copayment of \$12.00
After the applicable Copayment is satisfied, The Plan Will Pay	100%	100%	100%

The Medical Pre-Existing Conditions Limitations shall not apply to Prescription Drug Expenses.

Unit Dose Limit -- the following Day Supply Maximums:

Participating Home Delivery Pharmacy	90 day supply
Participating Provider Pharmacy	30 day supply

Drug charges which are covered to any extent under this Prescription Drug Expense Benefit are not covered under any other Medical or Dental Care Benefits of this Plan. The Copayment for Prescription Drugs may not be used toward satisfaction of the Medical Care or Dental Care Deductible.

If a Covered Person does not have proof of prescription drug coverage on the date a prescription drug or medicine is purchased from a Participating Pharmacy, the Covered Person must pay the full cost of the covered prescription drug or medicine at the time of purchase. The Covered person must then submit a completed claim form along with prescription drug information to the address shown on the claim form. The Plan Will Pay Benefits, if any, to the Covered Person minus any applicable Copayment Amount.

PRESCRIPTION DRUG BENEFITS - Continued

When Injury or Illness causes You or Your dependent, while covered under the Plan, to incur Covered Prescription Drug Expenses, The Plan Will Pay Benefits for those Covered Expenses.

These Prescription Drugs and medicines must be prescribed by a Doctor and obtained from a licensed Pharmacist or Doctor operating within the scope of his/her license. You or Your dependent incurs an expense on the date the drug or medicine is furnished.

Prescription Drug Generic Option

(This Example Applies to the Home Delivery Pharmacy)

If a Generic Drug is available but Your Doctor specifies "Dispense as Written," You pay only the brand name drug copayment. If a Generic Drug is not available, You pay only the brand name drug copayment.

However, if Your Doctor allows substitution and You request the brand name drug, You must pay the brand name drug copayment PLUS the difference in cost between the Generic and brand name drug.

EXAMPLE:	Brand Name Drug	\$50.00	Copayment	\$40.00
	Generic Drug	\$30.00	Copayment	\$24.00

If a Generic Drug is dispensed, You pay \$24.00.

If a Generic Drug is not available, You pay \$40.00.

If a brand name drug is dispensed at Doctor's request, You pay \$40.00.

If a brand name drug is dispensed at Your request (substitution allowed by Doctor), You pay \$60.00 ($\$50.00 - \$30.00 + \$40.00 = \60.00).

Formulary Brand Option

If Your Doctor prescribes a name brand drug that has been selected as a Formulary Brand, You pay the Formulary Brand Copayment. Your Employer will provide You with an initial list of Formulary Brands. This list is reviewed annually and can change. You may check whether a Brand Name drug is still on the list or if new Brand Name drugs have been added by referring to the current year's listing available from Your Employer.

If Your Prescription is not for a drug on this list, You will pay the appropriate All Other Brands or Generic Copayment.

Home Delivery Maintenance Prescription Drug Option

Most Maintenance Prescription Drugs are available through the Home Delivery Pharmacy. You pay a Copayment based upon whether the drug is a Generic, a Formulary Brand or a Non-Formulary Brand Prescription Drug. The list of Formulary Brands is the same for both retail Pharmacies and the Home Delivery Pharmacy.

Prescription Drug Definitions

1. "Generic Drug" means a Prescription Drug known by its chemical name rather than by brand name.
2. "Home Delivery Pharmacy" means a U.S. pharmacy which has a written contract with Us or Our authorized representative for Home Delivery of Maintenance Prescription Drugs.

PREScription DRUG BENEFITS - Continued

3. "Home Delivery" means the Maintenance Prescription Drugs are delivered directly to You or Your dependent by mail.
4. "Maintenance Prescription Drug" means a Prescription Drug that You or Your dependent will take or use for more than 30 days.
5. "Pharmacy" means a licensed establishment where drugs are dispensed by a Pharmacist licensed in that state. "Pharmacy" also includes a Hospital Pharmacy. "Participating Pharmacy" means a U.S. Pharmacy which has a written contract with Us or Our authorized representative.
6. "Prescription" means the request for a drug by a Doctor licensed to prescribe drugs and each authorized refill.
7. "Prescription Drug" means a prescription legend drug which is:
 - a. medicine required by federal law to bear the legend, "Caution: Federal law prohibits dispensing without a Prescription";
 - b. any other drug which, under the applicable state law, may only be dispensed upon the Prescription order of a Doctor.

We will also consider the following to be Prescription Drugs:

- a. needles and syringes when used for diabetes injections;
- b. tretinoin, all dosage forms (e.g. Retin-A), for persons through the age of 17 years;
- c. injectable insulin;
- d. birth control pills;
- e. Prescription pre-natal vitamins;
- f. diabetic supplies such as glucose strips, alcohol swabs, and lancets;
- g. Adderol and other Attention Deficit Disorder Prescriptions, for persons through the age of 17 years; and
- h. Ritalin.

Prescription Drug Exclusions

Your Employer has chosen to provide many Benefits. There are some things, however, that will not be covered as Prescription Drug Benefits. These are:

1. Drugs or medicines prescribed for Injury or Illness arising out of employment, whether or not You or Your dependent is are covered by Worker's Compensation or similar laws.
2. Drugs or medicines which can be legally obtained without a Prescription, except those items included in the definition of "Prescription Drug."
3. Hypodermic needles and syringes, except when used for diabetes injections.
4. Drugs or medicines provided without charge.
5. The administration of drugs or insulin.
6. Drugs or medicine marked "Caution: Limited by federal law to investigational use."
7. Experimental drugs or medicines; or investigational drugs.
8. Drugs or injectable insulin in a quantity greater than that prescribed by a Doctor.
9. Drugs or injectable insulin purchased more than one year after the date of the Prescription.
10. Drugs or insulin while confined in a Hospital, Skilled Nursing Facility or a similar facility.
11. Healing devices; immunization agents; organic serum, blood or blood plasma; drugs given as shots other than insulin; vitamins, diet aids, health or beauty aids; birth control devices or supplies; delivery charges.
12. That part of one purchase of a drug or medicine that exceeds the Unit Dose Limit specified on the Schedule.

PRESCRIPTION DRUG BENEFITS - Continued

13. The following items (whether brand name or Generic) will not be covered regardless of the reason prescribed:
 - a. Tretinoin, all dosage forms (e.g. Retin-A), for individuals 18 years of age or older, unless pre-authorized;
 - b. growth hormone drugs or medicines;
 - c. Levonorgestrel (Norplant);
 - d. Minoxidil (Rogaine) for the treatment of alopecia;
 - e. Implantable time-released medication unless otherwise noted;
 - f. anorectics (any drug or medicine used for the purpose of weight loss);
 - g. diet supplements, except those required for the treatment of genetic inborn errors of metabolism or nutritional supplements ;
 - h. infertility drugs or medicines;
 - i. allergens (any treatment related to the suppression of allergies);
 - j. Adderol and other Attention Deficit Disorder Prescriptions for individual 18 years of age or older, unless pre-authorized; and
 - k. impotency drugs (e.g. Viagra), unless pre-authorized.
14. Drugs dispensed by a non-participating pharmacy.
15. Extemporaneously prepared combinations of raw bulk chemical ingredients(i.e. progesterone, testosterone, or estrogen powders) or combinations of federal legend drugs in a non-FDA approved dosage form

DENTAL CARE BENEFITS

SCHEDULE

Dental Care Expense

Services	The Plan Will Pay
Prophylaxis (Cleaning)	100% after the Covered Person pays a \$15 Copayment per visit.
Preventive and Diagnostic Care	100%
Basic Dental Care	50%
Prosthetic Care	50%
Orthodontic Care for dependent Children under age 19	50%
Replacement of a Denture (except when payable under Basic Dental Care)	50%
Maximum Benefit for Covered Dental Care Expenses Incurred in any Calendar Year excluding Orthodontic Care	\$2,500
Maximum Lifetime Year Benefit for Covered Orthodontic Care	\$1,200

When You or Your dependent incurs Covered Dental Care Expenses exceeding the Deductible, The Plan Will Pay Benefits for those expenses up to the maximums shown on the Schedule.

Late Enrollee Dental Restriction

In the case of a person whose Dental Care coverage begins more than 31 days after the person becomes eligible, the Covered Expenses received during the first year the Benefit is in effect will be limited to the Preventive and Diagnostic Care and to those made necessary by an accident occurring while covered.

Mandatory Pre-Determination of Dental Benefits

Pre-Determination of Dental Benefits must be requested by a Covered Person when the estimated amount of charges will be \$500 or more.

We will review the description of planned treatment and expected charges, including those for diagnostic x-rays. This information should be sent to Us before the dental work is started if the Covered Person requests the Pre-Determination of Benefits. If there is a major change in the treatment plan, a revised plan should be submitted for review.

When more than one dental service could provide suitable treatment based on common dental standards, We will determine the basis upon which payment will be made and the expenses that will be included as Covered Dental Care Expenses.

When there has not been a Pre-Determination of Benefits, We will determine the expenses that will be included as Covered Dental Care Expenses at the time the claim is received.

Pre-Determination of Benefits does not guarantee payment. The estimate of Benefits payable may change based on the Benefits, if any, for which a Covered Person qualifies at the time services are completed.

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DENTAL CARE BENEFITS - Continued

Covered Dental Care Expenses

The Plan Will Pay Benefits as shown on the Schedule for the following Covered Dental Care Expenses:

1. Preventive and Diagnostic Care which means:
 - a. initial oral examination;
 - b. clinical oral exams, but not more than two per calendar year;
 - c. histopathologic examination;
 - d. diagnosis;
 - e. diagnostic casts;
 - f. complete mouth survey of x-rays consisting of at least 14 films, but not more than one survey in 24 consecutive months;
 - g. individual periapical x-rays (up to 12);
 - h. bitewing x-rays, but not more than one series in 6 consecutive months;
 - i. occlusal x-rays;
 - j. extra-oral x-rays;
 - k. bacteriologic culture;
 - l. topical application of fluoride for Your dependent Child under age 15, but not more than one per calendar year;
 - m. dental prophylaxis (including scaling and polishing) for covered persons age 15 and over, but not more than two per calendar year;
 - n. dental prophylaxis for Your dependent Children under age 15 and over, but not more than two per calendar year; and
 - o. pit and fissure sealants to posterior teeth only for Your dependent Child under age 18, but not more than one treatment per calendar year.
2. Basic Dental Care which means remedial and restorative care and supplies for:
 - a. necessary examinations and diagnostic services (including x-ray and laboratory tests) when such services are not covered as Preventive and Diagnostic Care;
 - b. extractions of erupted teeth;
 - c. fillings (amalgams);
 - d. repair of complete or partial dentures;
 - e. space maintainers for Your dependent Child under age 12, but not more than 1 per calendar year;
 - f. root canal therapy (endodontic care);
 - g. treatment of the gums and tissues of the mouth (periodontic treatment);
 - h. emergency care for the relief of pain (palliative care);
 - i. the giving of anesthesia in connection with dental care;
 - j. repair and relining of complete or partial dentures;
 - k. Replacement of Dentures if required due to:
 - i. removal of natural teeth while covered under the Plan;
 - ii. the initial placement of an opposing full denture;Replacement of Dentures for any other reason will be covered only as described under Prosthetic Care below;
 - l. prescription drugs dispensed by a licensed Pharmacist; and
 - m. oral surgery.
3. Prosthetic Care which means:
 - a. inlays and onlays;
 - b. initial installation of full or partial dentures;
 - c. bridgework; and
 - d. crowns.
4. Replacement of Dentures
5. Orthodontic Care for dependent Children under age 19 which means:
 - a. preparing teeth and jaw for orthodontic treatment;
 - b. furnishing orthodontic devices; and
 - c. installing the devices.

DENTAL CARE BENEFITS - Continued

Dental Care Exclusions

Your Employer has chosen to provide many Benefits. There are some things, however, that will not be covered as Dental Care Benefits. These are:

1. Dental care or supplies which are not included under Covered Dental Care Expenses.
2. Dental care or supplies furnished by a facility operated for or by the U.S. Government (or its agency) or by a Doctor employed by that place.
3. Dental care and supplies for which:
 - a. no charge is made;
 - b. You or Your dependent would not have to pay if You did not have this coverage.
4. Intentionally self-inflicted Injury.
5. Dental care or supplies furnished as of result of taking part in the commission of an assault or felony.
6. Dental care or supplies furnished as a result of an Illness covered by Worker's Compensation, occupational disease law or similar laws; or Injury if it arises out of or during the course of employment for pay or profit.
7. Dental care or supplies payable under another part of the Plan.
8. Dental care or supplies furnished as a result of:
 - a. act of war (declared or undeclared);
 - b. insurrection or Riot.
9. Charges incurred after the Covered Person is no longer covered for this Dental Care Benefit.
10. Supplies for dental care other than those used in a Doctor's office; or instructions in dental hygiene.
11. Oral care and supplies which are used to change vertical dimension or closure. These include but are not limited to:
 - a. diagnostic procedures;
 - b. balance procedures;
 - c. restoration;
 - d. fixed devices;
 - e. movable devices.
12. Orthodontia for Covered Persons over age 19.
13. Any service rendered by a Close Relative or someone having the same legal residence as the patient.
14. Dental implants.

VISION CARE BENEFITS

SCHEDULE

Employee and Dependent Coverage

Vision Care Expenses	Maximum Benefit Amounts
Complete Examination	The Plan Will Pay 100% after the Covered Person pays a \$15 Per Visit Fee.
Supplies:	
Lenses	
Single Vision Prescription	\$20.00
Bi-focal Prescription	\$35.00
Tri-focal Prescription	\$55.00
Lenticular Prescription	\$150.00
Contact Lenses	\$45.00 (the total amount allowed for frames and eyeglass lenses).
Frames	\$25.00

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When You and Your covered dependents incur Covered Vision Care Expenses, The Plan Will Pay Benefits for those expenses up to the maximums shown on the Schedule.

The Plan Will Pay Benefits for the following covered Vision Care expenses:

1. One Complete Eye Examination and History performed by a licensed optometrist or Physician in any one 12 month period.
2. Two contact (includes disposable lenses) or eye glass lenses (not both) prescribed by a licensed optometrist or Physician in any one 12 month period. The Plan Will Pay for more than two lenses if required after cataract surgery.
3. One eye glass frame in any one 24 month period.

Vision Definitions

"Complete Eye Examination and History" means an eye examination that includes a new prescription if needed.

Vision Care Exclusions

Your Employer has chosen to provide many Benefits. There are some things, however, that will not be covered as Vision Care Benefits. These are:

1. Care and supplies:
 - a. for special procedures, such as orthoptics and visual training;
 - b. for medical or surgical treatment;
 - c. provided under Worker's Compensation, or similar laws;
 - d. needed for an Injury or Illness arising out of employment.

VISION CARE BENEFITS - Continued

2. Prescription sunglasses.
3. Non-prescription glasses or sunglasses.
4. Eye exam required:
 - a. as a condition of employment required under a labor agreement;
 - b. by a government body.
5. Vision care and supplies for which:
 - a. no charge is made;
 - b. You or Your dependent would not have to pay if You did not have this coverage.
6. Vision care and supplies furnished by a facility operated for or by the U.S. Government (or its agency) or by a Doctor employed by that place unless:
 - a. for emergency treatment when You or Your dependent must pay for those services;
 - b. for non-service connected disabilities in a Veteran's Administration Hospital;
 - c. incurred by a U.S. military retiree (covered by this Plan) or his/her covered dependents, while confined in a military medical facility.
7. Vision care and supplies to the extent furnished or payable under:
 - a. a plan or program operated by a National Government or one of its agencies;
 - b. a State Cash Sickness or similar law including any group insurance policy approved under such laws;
 - c. another plan of Your Employer.
8. Intentionally self-inflicted Injury.
9. Injury or Illness as a result of taking part in the commission of an assault or felony.

CLAIMS AND OTHER GENERAL PROVISIONS

Notice and Proof of Claim

You must give Us a written notice of claim for a health claim (including vision and dental claims, if any), within 90 days after a Covered Expense is incurred.

Within 15 days after We receive the notice of claim, We will send claim forms to You for giving proof of claim. If You do not receive these forms, You will satisfy the proof of claim requirement by giving Us a written statement of the nature and extent of the loss within the time limit provided below.

You must give positive proof of claim to Us or Our authorized claim office for a health claim (including vision and dental claims, if any) within 12 months after a Covered Expense is Incurred.

You must give Us proper written notice and proof of loss before We will be liable for any loss. If You send Us proof as soon as reasonably possible, We will not reduce or deny claims merely because You cannot reasonably give notice and proof in writing within the time required.

We may, as required by law, accept claims submitted by a third-party custodial parent or a provider (with the custodial parent's approval) for Covered Expenses Incurred by a covered dependent Child who is also eligible for a state medical assistance program (i.e., Medicaid).

Payment of Claims

1. All benefits due and not validly assigned will be paid to you as soon as we receive due proof.
2. If You die before The Plan Pays all of the Benefits to You, the Plan may pay any remaining Benefits in this order:
 - a. to Your spouse, if living;
 - b. to Your surviving children, in equal shares;
 - c. to Your parents, in equal shares, or to the survivor; or
 - d. to Your estate.
3. In any case where the person to whom We would pay Benefits cannot give a valid release, The Plan Will Pay any remaining Benefits in this order:
 - a. to Your spouse, if living;
 - b. to Your surviving children, in equal shares;
 - c. to Your parents, in equal shares, or to the survivor; or
 - d. to Your estate.If no person listed above survives You, the Plan may pay Benefits to the person or institution it determines gave the Covered Person care.
4. The Plan may, to the extent required by law, pay Benefits for claims incurred by a covered dependent Child directly to a custodial parent, a state agency or a provider.
5. Benefit payments pursuant to a qualified medical child support order (QMCSO) in reimbursement for expenses paid by a QMCSO-child or his/her legal representative (custodial parent or legal guardian) will be made to the QMCSO-child or his/her legal representative.
6. If You use a Participating Provider, The Plan Will Pay Benefits, if any, to the provider of service.
7. The Plan may pay Benefits to the person or institution who gave You care.
8. Any payments We make under the above, will discharge Our liability to the extent of Our payment. We are not responsible for how the Benefits We pay are used.

Legal Actions

You may not sue Us for Benefits under the Plan:

1. before 60 days following the date You send Us proof of claim;
2. after 3 years following the end of the period required for giving proof of claim.

CLAIMS AND OTHER GENERAL PROVISIONS - Continued

Claim Decisions

1. Decisions on medical, dental or vision claims will be made within 30 days of the date We receive the claim. If a decision cannot be made for reasons beyond control of the Plan, We will notify You of:
 - a. the reason for the delay;
 - b. any information needed to perfect the claim; and
 - c. the date by which We expect to make a decision.

You will have 45 days from the date You receive the notice to provide the requested information. If We receive the necessary information within the 45 day time frame, a decision will be made within 15 days of Our receipt of the information, unless You agree to a longer period of time. If You do not provide the requested information within this time period, You should consider the claim to be denied. This denial will be reconsidered if the information is subsequently received.

2. Decisions on claims involving Pre-Treatment Authorization, Concurrent Review or Retrospective Review will be made in accordance with the procedures shown in the Managed Health Care section of the Plan.

In the event a claim (other than a request for Pre-Treatment Authorization or Concurrent Review) is denied in whole or in part You will be notified in writing of the following:

1. the reason for denial;
2. specific reference to the Plan provisions on which the denial was based;
3. any additional material or information needed for further review of the claim;
4. an explanation of the Plan's review procedure and time limits;
5. with respect to medical, dental or vision, the specific rule, guideline, protocol or similar criterion, if any, that was relied upon in deciding the claim, or a statement that such was relied upon and is available upon request;
6. with respect to medical, dental or vision claims, an explanation of the scientific or clinical judgment for determining a denial based on a medical judgment, Medical Necessity, or treatment that is Experimental, Investigational or Unproven, or a statement that such explanation is available free of charge upon request.

If a claim is denied in whole or in part, You, the Covered Person's Doctor or other Authorized Representative may appeal the denial by making a written request for review to Us within:

1. 180 days of the time You receive the notice of denial of the initial claim or within 60 days of the time You receive the notice of denial of Your first appeal with respect to medical, dental or vision claims;
2. 60 days of the time You receive the second notice of denial for the purpose of submitting a voluntary appeal.

"Authorized Representative" means the Covered Person's spouse, parent, Doctor or Hospital. It will also include any other person who submits proof that he or she has been designated by the Covered Person or court of law to act on such person's behalf.

In connection with Our review of the appeal, You have the right to 1) see the Plan and other relevant papers affecting the claim, 2) argue against the denial in writing, 3) have a representative act on Your behalf in the appeal. All comments, documents, records and other information submitted in connection with the claim being reviewed will be considered.

CLAIMS AND OTHER GENERAL PROVISIONS - Continued

With respect to medical, dental or vision claim reviews, the review will be conducted by someone other than the person who made the initial determination. If the initial denial was based on a medical judgment, Medical Necessity or treatment that is Experimental, Investigational or Unproven, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted. If the claim is still denied in whole or in part, You will again be advised as per items 1. through 6., above, along with Your right to request information regarding any voluntary appeals provided under Your Plan once the required appeals have been exhausted. Voluntary appeals are not applicable to decisions involving Medical Necessity or treatment considered to be Experimental, Investigational or Unproven.

The decision on the appeal shall be in writing, and shall be made within 30 days of the date We receive the request for review with respect to medical, dental or vision claims.

The decision shall include specific reasons for the denial, written in a manner understandable to You and contain specific reference to the pertinent Plan provisions on which the decision was based.

Once the required appeals previously described have been exhausted, additional appeals are allowed on a voluntary basis upon request for medical, dental or vision claims. There are no voluntary appeal rights following the previously described appeal process when the denial was based on Medical Necessity or on a determination that the treatment was considered Experimental, Investigational or Unproven. You may request information regarding voluntary appeals procedures.

Refer to the Managed Health Care section of the Plan for information about Pre-Treatment Authorization, Concurrent Review and Retrospective Review claim denials.

Assignment of Benefits

You may assign Medical or Health Care Benefits directly to the Doctor, Hospital or an appropriate state agency. You may assign Dental Care Benefits directly to the provider. You can either sign the necessary forms given to You by the provider of services or sign the designated assignment on Your claim form. Otherwise, Benefits will be paid according to the Payment of Claims provision. If You use a Participating Provider, The Plan Will Pay Benefits, if any, to the provider of service. We will not be responsible for the validity of any assignment. Nor will We be liable for any action, payment or other settlement made before We receive such assignment.

To the extent permitted by law, neither the Benefits nor payments under the Plan will be subject to the claim of creditors or to any legal process.

Physical Examinations

We may have a Doctor of Our choice examine You, as often as is reasonably necessary while Your claim is pending. We may also have an autopsy performed, except if prohibited by law.

Incontestability and Misstatement

We cannot contest your coverage after it has been in force for two years unless required contributions are not paid. We cannot contest Your coverage after the Plan has been in force for two years during Your lifetime unless required Contributions are not paid. However, no provision of this Plan shall make the coverage of an ineligible person valid.

Any statement about Your health or age made in writing and signed by You may be used to contest Your coverage.

If you misstate Your age, The Plan Will only Pay Benefits based on Your correct age. The Plan will a) adjust required contributions, b) validate, or c) void coverage as necessary.

CLAIMS AND OTHER GENERAL PROVISIONS - Continued

Refund to us for Overpayment of Benefits

If You or Your dependent recover money for medical, hospital, dental or vision expenses incurred due to an illness or injury for which a benefit has been paid under this plan, we will have the right to a refund from You or Your dependent. The amount refunded to us will be the lesser of:

1. the amount You or Your dependent recover;
2. the amount of benefits we have paid.

You or Your dependent (or a parent or legal guardian, if required) will help us do whatever else may be reasonably needed to obtain this refund.

Right of Subrogation

If You or Your covered dependent has a claim for damages or a right to recover damages from another party or parties for any Illness or Injury for which benefits are payable under this Plan, We are subrogated to such a claim or right of recovery. Our right of subrogation will be to the extent of any Benefits paid or payable under this Plan, and shall include any compromise settlements. We may assert this right independently of the Covered Person. Acceptance of Benefits is constructive notice of this provision in its entirety.

If a Covered Person, or legal representative, estate or heir of the Covered Person, recovers damages, by settlement, verdict or otherwise, for an Illness or Injury for which a Benefit has been paid under this Plan, the Covered Person, or legal representatives, estate or heirs of the Covered Person, agrees to promptly reimburse Us for Benefits paid. Our right to receive reimbursement applies to the Covered Person's recovery from any source, including but not limited to any party's liability and medical pay insurance, uninsured and underinsured motorist coverage, no-fault automobile coverage and Workers' Compensation coverage.

We will have a first lien upon any recovery, whether by settlement, judgment, arbitration or mediation, that the Covered Person receives or is entitled to receive from any source, regardless of whether the Covered Person receives a full or partial recovery. Any settlement or recovery received shall first be deemed to be reimbursement of medical expenses paid under this Plan. Our first priority rights will not be reduced due to the Covered Person's own negligence.

We are entitled to reimbursement even if the Covered Person is not made whole or fully compensated by the recovery. Any share of attorney fees or costs or Common Fund fees shall not reduce our recovery unless agreed to by Us in writing.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of whether the minor's representative has access to or control of any recovery funds.

The Covered Person (or parent or legal guardian) will cooperate with Us and our agents and help Us do what may be reasonably needed to protect the Plan's subrogation rights and obtain the refund. This includes furnishing all relevant information, making assignments in Our favor and signing and delivering any documents needed to protect Our rights. The Covered Person shall not take any action that prejudices Our rights.

If the Covered Person makes a recovery from any source and fails to reimburse Us the lesser of:

1. the amount recovered (including amounts to be recovered through future installment payments), or
2. the amount of Benefits paid related to this Illness or Injury,

the Covered Person will be personally liable to Us for this amount. We may also offset future benefits up to the amount due to Us.

The terms of this subrogation and right of reimbursement provision shall apply regardless of state laws to the contrary.

GENERAL DEFINITIONS

When these terms are used in the Plan, they will have the following meanings unless otherwise noted:

1. **Active Work/Actively at Work:** means You work for Your Employer at his/her place of business (or such other places as required by Your Employer) in accordance with his/her established employment practices.
2. **Average Semiprivate Room Charge:** means a) the standard charge by the Hospital for semiprivate room and board accommodations, or the average of such charges where the Hospital has more than one level of such charges, or b) 80% of the Hospital's lowest charge for single bed room and board accommodations when the Hospital does not provide any semiprivate accommodations.
3. **Benefit(s):** means the amount The Plan Will Pay for Covered Expenses after You or Your covered dependents have met the Deductible, if any.
4. **Birth Center:** means a licensed place with the primary purpose of providing a place for live births operating within the scope of its license.
5. **Close Relative:** means You, Your spouse, and Your or Your spouse's brother, sister, parent, or Child.
6. **Co-insurance:** Predetermined percentage of eligible charges that the plan will pay, in accordance with the provisions stated in the Plan.
7. **Complications of Pregnancy:** means a disease, disorder or condition which is diagnosed as distinct from normal pregnancy but adversely affected by or caused by pregnancy. This includes:
 - a. inter-abdominal surgery, including cesarean section;
 - b. pernicious vomiting (hyperemesis gravidarum);
 - c. toxemia with convulsions (eclampsia);
 - d. extra-uterine pregnancy (ectopic);
 - e. postpartum hemorrhage;
 - f. rupture or prolapse of the uterus;
 - g. spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible;
 - h. similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will not include:

- a. elective abortion;
- b. false labor;
- c. occasional spotting;
- d. Physician prescribed rest;
- e. morning sickness;
- f. similar conditions associated with the management of a difficult pregnancy.

Services and supplies rendered at the termination of pregnancy will not be considered treatment of Complications of Pregnancy.

8. **Contributions:** mean the amount You are required to pay for the coverage provided under the Plan.
9. **Co-payment:** Co-payments means the predetermined charge that the employees must pay directly to the Provider of services for certain health care services. The co-payment is to be paid at the time of treatment is rendered and does not count towards the deductible or co-insurance specified in the plan.

GENERAL DEFINITIONS - Continued

10. **Covered Expense:** means a listed Covered Expense under a Benefit description which will be paid under the Plan if it is:
- prescribed by a Doctor or Dentist for the therapeutic treatment of Injury, Illness or pregnancy;
 - Medically Necessary;
 - not more than what We determine as Reasonable and Customary; and
 - not excluded under any exclusions of the Plan.

If You use a Participating Provider, Covered Expense means the agreed upon rate set between Us and such provider for services which meet all of the above standards.

11. **Covered Person:** means an Enrolled person meeting the eligibility requirements of the Plan.

12. **Creditable Coverage:** means any of the following coverages a Covered Person had prior to enrollment under the Plan:

- a group health plan;
- health insurance coverage, individual and group, including coverage through a Health Maintenance Organization (HMO);
- Medicare;
- Medicaid;
- military health care;
- a medical care program of the Indian Health Service or of a tribal organization;
- a state health risk pool;
- a health plan offered under the Federal Employee Health Benefits Program;
- a public health plan established or maintained by a political subdivision of a state to provide insurance coverage;
- a health benefit plan established by the Peace Corps Act.

13. **Custodial Care:** means services, provided by a licensed, skilled nurse or a non-skilled person, for:

- a person with a chronic medical condition; or
- a convalescent person.

This care basically provides assistance to a person in daily living; it does **not** require technical skills or qualifications. This care is not reasonably expected to improve the underlying medical condition of a person even though it may relieve symptoms or pain.

Custodial Care includes, but is not limited to:

- help in grooming, bathing, dressing, walking;
- help in getting in and out of bed;
- help in housekeeping, preparing meals, and eating;
- giving or helping to use or apply medications, creams and ointments;
- administering medical gasses after a therapy program has been set up;
- changing dressings, diapers and protective sheets;
- periodic turning and positioning in bed;
- routine care of casts, braces and other like devices;

GENERAL DEFINITIONS - Continued

- i. routine care of colostomy and ileostomy bags;
- j. routine tracheostomy care;
- k. routine care of catheters and other like equipment; and
- l. supervising exercise programs that do not need the skills of a therapist.

Care that does require the technical skills of a licensed medical professional, who is acting within the scope of his/her license, is not considered to be Custodial Care.

14. **Deductible:** Deductible means the amount that the employee must pay for covered services before the plan is obligated to provide reimbursement. Deductibles are based on a calendar year unless otherwise identified.
15. **Dentist:** means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of that license. For the purpose of this definition, a Physician will be considered to be a Dentist when he/she performs any of the dental services included under Covered Dental Care Expenses and is operating within the scope of his/her licenses.
16. **Disabled:** means that due to Illness or Injury You cannot perform the material and substantial duties of Your regular occupation or Your covered dependent cannot perform normal activities, except as provided elsewhere in the Plan.
17. **Doctor:** means a medical Practitioner licensed to perform surgery and administer drugs acting in the scope of that license. It will also include any other licensed Practitioner of the healing arts required to be recognized by law, when that person is acting within the scope of his/her license and is performing a service for which Benefits are provided under the Plan.

"Practitioner" means a person who is legally entitled to perform certain medical services according to applicable licensure or certification in the state or jurisdiction where the services are rendered. The person must be acting within the scope of his or her license and must hold one of the following degrees and/or titles: Certified Nurse Practitioner (C.N.P.); Certified Family Nurse Practitioner (C.F.N.P.); Certified Nurse Midwife (C.N.M.); Certified Registered Nurse Anesthetist (C.R.N.A.); Registered Physical Therapist (R.P.T.); Psychologist (Ph.D., D.Ed., Psy.D., M.S.); Licensed Clinical Social Worker (L.C.S.W., L.C.S.W.II); Master of Social Welfare (M.S.W.); Marriage, Family, Child Counselor (M.F.C.C., M.Ed., M.A.); Registered Speech Therapist (R.S.T.); Physician's Assistant (P.A.); Registered Acupuncturist (R.A.); Certified Homeopath (R.H.); Certified Naturopath (C.N.); Licensed Professional Counselor (L.P.C.); Registered Respiratory Therapist (R.R.T.); or Optometrist (O.D.); Registered Dental Hygienist (R.D.H.).

18. **Emergency:** means an accidental Injury or Emergency Medical Condition which reasonably requires You or Your dependent to seek immediate medical care within no later than 48 hours after the Injury or the onset of the Emergency Medical Condition.

Medical conditions which manifest themselves by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in:

- a. placing the patient's health in serious jeopardy;
- b. serious impairment of bodily functions; or
- c. serious dysfunction of any bodily organ or part,

will be considered "Emergency Medical Conditions."

19. **Emergency Care:** means covered services rendered after the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
- a. placing the patient's health in serious jeopardy;
 - b. serious impairment of bodily functions; or
 - c. serious dysfunction of any bodily organ or part.

GENERAL DEFINITIONS - Continued

20. **Employer:** means the entity to which the Plan is issued and includes any affiliated entities or subsidiaries or Associated Companies shown in the Eligible Class or Classes section of the Group Plan.
21. **Enroll:** means completion of all forms required for coverage under the Plan and agreement to make any required Contribution.
22. **Enrollment Date:** means the first day of coverage following the Waiting Period.
23. **Expense Incurred:** means each expense is considered to be incurred on the date the care, service or supply is received.
24. **Experimental, Investigational or Unproven:** means care and treatment for which We determine that one or more of the following is true:
- a. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indicators. Clinical trials include but are not limited to phase I, II and III clinical trials.
 - b. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.
We determine if this item b. is true based on:
 - i. published reports in authoritative medical literature; and
 - ii. regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, the federal Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), or any other appropriate technological assessment body.
 - c. In the case of a drug, a device or other supply that is subject to FDA approval:
 - i. it does not have FDA approval; or
 - ii. it has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
 - iii. it has FDA approval, but it is being used for an indication or at a dosage that is not an Accepted Off-Label Use. An "Accepted Off-Label Use" is a use that is:
 - a) included and favorably recognized for treatment of the indication in one or more of the following medical compendia: The American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and The United States Pharmacopoeia Information; or
 - b) established based on supportive clinical evidence in peer-reviewed medical publications.
 - d. The providers institutional review board acknowledges that the use of the service or supply is Experimental, Investigational, or Unproven and subject to that board's approval.
 - e. Research protocols indicate that the service or supply is Experimental, Investigational, or Unproven. This item e. applies for protocols used by the Covered Person's provider as well as for protocols used by other providers studying substantially the same service or supply.
25. **Family Unit:** means You and all of Your dependents who are covered under the Plan.

GENERAL DEFINITIONS - Continued

26. **Full-Time Basis:** means You work Your full number of hours for Your full rate of pay as required by Your Employer. The amount of required work time per week may never be less than 20 hours.
27. **Home Health Care Agency:** means a home health service or agency operating under a valid certificate of approval issued under the statutes of the state where services are provided.
28. **Hospice:** means an agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and meets all of the following tests:
- a. it has obtained any required governmental Certificate of Need approval;
 - b. it provides service for a period of 24 hours per day on every day of the week;
 - c. it is operated under the direct supervision of a duly qualified Doctor;
 - d. it has a nurse coordinator who is a registered graduate nurse with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients;
 - e. it has a social service coordinator who is licensed in the jurisdiction in which it is located;
 - f. it is an agency that has as its primary purpose the provision of Hospice services;
 - g. it has a full-time administrator;
 - h. it maintains written records of services provided;
 - i. its employees are bonded, and it provides malpractice and malplacement insurance;
 - j. it is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.
29. **Hospital:** means a place which meets all of the standards below:
- a. has permanent and full-time care for bed patients;
 - b. is under the supervision of a Physician;
 - c. has an R.N. on duty or call 24 hours a day;
 - d. is mainly engaged in giving medical care and services for Injuries or Illness but not including:
 - i. rest homes;
 - ii. nursing homes;
 - iii. convalescent homes;
 - iv. homes for the aged;
 - e. has surgical facilities except that this standard does not apply to such place operated mainly for treatment of the chronically ill;
 - f. is operated lawfully in its area.
- "Hospital" also means such place which is mainly engaged in treating Alcoholism and Drug Abuse or addiction if it meets the standards below:
- a. has permanent and full-time care for at least 15 bed patients;
 - b. has a Doctor in regular attendance;
 - c. provides 24 hour per day care by R.N.s;
 - d. has a full-time psychiatrist or psychologist on the staff.

GENERAL DEFINITIONS - Continued

Hospital also means and will include an "Ambulatory Surgical Center" which meets all of the standards below:

- a. is a licensed public or private place;
 - b. has an organized medical staff of Doctors;
 - c. has permanent facilities that are equipped and operated mainly for doing surgery and giving skilled nursing care;
 - d. has R.N. services when a patient is in the facility; and
 - e. does not provide services or beds for patients to stay overnight.
30. **Illness:** means sickness, or a covered dental infirmity, a covered bodily or mental infirmity or pregnancy.
31. **Injury:** means a covered accidental bodily Injury.
32. **Inpatient Hospital Confinement:** means a confinement in a Hospital as a bedpatient for which room and board charges are made by the Hospital to the Covered Person.
33. **Intensive Care Unit:** means a specifically named area in a Hospital operated only to give care to critically ill patients, with special supplies and equipment available for immediate use, providing room and board and bedcare under the constant watch of a highly trained Hospital staff. Normal post-operative or recovery room care is not intensive care no matter where located.
34. **Late Enrollee:** means an Eligible Employee or Dependent who requests Enrollment in the Employer's health benefit plan other than during the initial enrollment period or during the Special Enrollment Periods provided under the terms of the Plan.
35. **L.P.N.:** means a licensed practical nurse acting in the scope of his/her license.
36. **L.V.N.:** means a licensed vocational nurse acting in the scope of his/her license.
37. **Managed Care:** means the determination of availability of coverage through the use of clinical standards to determine the Medical Necessity of an admission or treatment, and the level and type of treatment, and Appropriate setting for treatment, with required authorization on a concurrent or retrospective basis, sometimes involving case management.
38. **Medically Necessary:** means that We determine that the care and treatment given meets all of the following conditions:
- a. it is Appropriate care and consistent with the diagnosis and symptoms. "Appropriate" means the type, level and length of service and setting are needed to provide safe and adequate care and treatment and are provided by the Appropriate provider acting within the scope of his/her license;
 - b. it is generally accepted medical practice and meets professionally recognized standards;
 - c. it is not deemed to be Experimental, Investigational or Unproven as defined herein;
 - d. it is not furnished in connection with medical or other research;
 - e. it is specifically allowed by the licensing statutes which apply to the provider who renders the service; and
 - f. it is at least as medically effective as any standard care and treatment.

GENERAL DEFINITIONS - Continued

We will use Our programs, or one established by Our authorized representative to determine whether care is needed and Appropriate. The program may include but is not limited to:

- a. Pre-Treatment Authorization;
- b. Concurrent Review; and
- c. Retrospective Review.

39. **Medicare:** means the plan of benefits provided by Title XVIII of the U.S. Social Security Act of 1965 as amended from time to time.
40. **Morbid Obesity:** means either 50% - 100% over normal weight, more than 100 pounds over normal weight.

The Body Mass Index (BMI) uses a persons weight and height to gauge total body fat. A BMI over 40 indicates that a person is morbidly obese. Criteria for surgical intervention for morbid obesity requires more than 100 pounds over ideal weight, obesity factor accompanied by 30 plus BMI or Morbid Obesity accompanied by 40 plus BMI.
41. **Out-of Pocket Maximum:** Out- of- Pocket Maximum means the maximum expense any member or family will be responsible for during a calendar year as indicated in the Plan of benefits, before the coinsurance percentage of the plan increases.
42. **Participating Provider:** means a Doctor or a Hospital that agrees with Us to provide Medically Necessary care and treatment at set rates.
43. **Participating Provider Organization (PPO):** means a Managed Care arrangement consisting of a network of Participating Providers that are available to provide medical services to Covered Persons.
44. **Pharmacist:** means a person who is licensed and trained to compound and dispense drugs and medicines acting within the scope of that license.
45. **Physician:** means a person licensed to practice medicine.
46. **Placed For Adoption:** means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement with You is considered terminated upon the termination of such legal obligation.
47. **Plan:** means the Benefits described in this Certificate as provided by the Self-funded Plan including all endorsements and amendments.
48. **Plan Claim Administrator:** means the entity designated by the Plan Sponsor to pay claims for benefits under this plan.
49. **Plan Sponsor:** means the City of Farmington, New Mexico which has established this employee welfare benefits plan for the purpose of providing health care coverage to its employees and dependents of such employees.
50. **Qualified Leave of Absence:** means leave of absence period approved by the Employer pursuant to the Family and Medical Leave Act of 1993 or other applicable leave that applies to the Employer.

GENERAL DEFINITIONS - Continued

51. **Reasonable and Customary:** means, with regard to charges for medical and dental services or supplies, the lowest of:
- a. the usual charge by the provider for the same or similar medical and dental services or supplies;
 - b. the usual charge of most providers of similar training and experience in the same or similar geographic area for the same or similar medical and dental service or supplies;
 - c. the actual charge for the medical and dental services or supplies; or
 - d. the negotiated rate a provider has agreed to accept.
- "Area" means a region We determine to be large enough to obtain a representative sample of providers of medical and dental care or supplies.
52. **Primary Care Provider or PCP:** means a Provider who supervises, ordines and provides initial and basic care Members, who initiates their referral for specialist care and who maintains continuity of patient care. Primary Care Providers include general practitioners and those who specialize in family practice, internal medicine or Pediatrics. All members may always self-refer to an OB/GYN for gynecological or obstetrical care without pre-authorization or pre-approval from the San Juan IPA or the PCP
53. **Replacement of Dentures:** means to substitute a different denture for one previously used. (This includes dentures that were lost, stolen or not in use.)
54. **Riot:** means all forms of violence, disorder, or disturbance of the public peace by three or more persons assembled together, whether or not acting with common intent or whether or not damage to persons or property or unlawful act or acts is the intent or the consequence of such disorder, violence or disturbance.
55. **R.N.:** means a licensed registered nurse acting in the scope of his/her license.
56. **Skilled Nursing Facility:** means a place other than a Hospital that:
- a. can provide permanent full-time care for 10 or more resident patients;
 - b. has a Physician who prescribes medications and treatment;
 - c. has an R.N. on full-time duty in charge of patient care;
 - d. has L.P.N.s or L.V.N.s on duty at all times under the supervision of an R.N.;
 - e. keeps a daily medical record for each patient;
 - f. is not mainly a rest home or a home for Custodial Care of the aged;
 - g. is not mainly engaged in treatment of drug addicts or alcoholics;
 - h. is operating lawfully as a nursing home.
57. **The Plan Will Pay:** means that when You send Us proof of claim, the Plan Claim Administrator will determine the Benefits payable and make payment, if any, according to the Payment of Claims provision, as detailed in this document.
58. **We, Us and Our:** means the Plan Sponsor (as represented by the Plan Claim Administrator).
59. **You and Your:** means an employee covered under the Plan.

Health Insurance Portability and Accountability Act NOTICE

In compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA), the following information is provided.

Plan Claims Administrator:

Benefits under this Plan are paid by:

San Juan IPA
2325 East 30th Street
Farmington, New Mexico 87401

The Medical Care, Dental Care, Vision Care, and Outpatient Prescription Drug Coverages for Employees and Dependents are funded and provided by the City of Farmington, New Mexico.

If you have any questions about Your Plan, You should contact the Plan Administrator.

Plan Administrator:

Director of Human Resources
City of Farmington, NM
800 Municipal Dr.
Farmington, NM 87401-2663

WHEREAS, the City of Farmington (the "City") maintains various benefit programs that provide medical, dental, vision, prescription drug, and employee assistance program ("EAP") benefits for eligible employees (hereinafter collectively referred to as the "Plan"); and

WHEREAS, the City is a Hybrid Entity whose activities include both covered and non-covered functions under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); and

WHEREAS, the City has designated the Plan as a Health Care Component of the Hybrid Entity and, as such, the Plan is a covered entity subject to the HIPAA privacy requirements; and

WHEREAS, the City now wishes to amend the Plan to comply with the regulations recently issued under the Health Insurance Portability and Accountability Act of 1996 concerning the privacy of health information (the "Privacy Rule");

WHEREAS, the City has reserved the right to amend the Plan and the undersigned has the authority to act on behalf of the Plan sponsor to amend the Plan;

NOW, THEREFORE, BE IT RESOLVED, that effective April 14, 2004, the Plan is hereby amended to add the following:

“HIPAA PRIVACY”

1. General. The Plan shall use, disclose, store, retain and, if applicable, destroy Protected Health Information in accordance with the Privacy Rule. The Plan shall comply with the standards for privacy of individually identifiable health information as set forth in the Privacy Rule.
2. Definitions. The following words and phrases, with the initial letter of each word capitalized, shall have the meanings indicated below.
 - (a) “Health Care Component,” as defined under 45 C.F.R. § 164.103, shall mean a component or combination of components of a Hybrid Entity designated by the Hybrid Entity in accordance with 45 C.F.R. § 164.105(a)(2)(iii)(C). The City, as a Hybrid Entity, has designated the Health Plan as a Health Care Component.
 - (b) “Health Care Operations,” as defined under 45 C.F.R. § 164.501, shall mean any of the following activities to the extent that they relate to a HIPAA Health Plan’s covered functions:
 - (i) Conducting quality assessment and improvement activities; population-based activities related to health improvement, reduction of health care costs, case management and care coordination; contacting health care providers and patients regarding treatment alternatives; and related functions that do not include treatment;
 - (ii) Reviewing competence or qualifications of health care professionals and evaluating provider and HIPAA Health Plan performance;
 - (iii) Underwriting and other activities that relate 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 claims for health care (including stop-loss insurance);
 - (iv) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
 - (v) Business planning and development, such as cost-management and planning-related analysis related to managing and operating the HIPAA Health Plan, and development or improvement of coverage policies; and
 - (vi) Business management and general administrative activities, including, but not limited to: (i) management activities related to implementation of and compliance with the requirements of the Privacy Rule; (ii) customer service, including the provision of data analyses for the HIPAA Health Plan sponsor, provided that PHI is not disclosed to the HIPAA Health Plan sponsor; (iii) resolution of internal grievances; (iv) due diligence related to the sale, transfer, merger, or consolidation of all or part of a HIPAA Health Plan with another entity directly regulated under the Privacy Rule, or an entity that, following such activity, will be subject to the Privacy Rule; and (v) consistent with applicable requirements of the Privacy Rule, creating de-identified information, as defined in 45 C.F.R. § 164.514(b)(2), or a limited data set, as defined under 45 C.F.R. § 164.514(e)(2).
 - (c) “Health Plan” shall mean each “group health plan, defined in 45 C.F.R. § 160.103, sponsored by the City to provide healthcare benefits for its employees, former employees and dependents, including but not limited to the following programs: medical, dental, vision, prescription drug, healthcare flexible spending accounts, executive physicals, employee assistance program, retiree medical, long-term care insurance, wellness programs and voluntary employee pay all health policies.
 - (c) “Hybrid Entity,” as defined under 45 C.F.R. § 164.103, shall mean a single legal entity that is a covered entity whose business activities include both covered and non-covered functions, and that designates Health Care Components in accordance with 45 C.F.R. § 164.105(a)(2)(iii)(C).

- (e) "Payment," as defined under 45 C.F.R. § 164.501, shall mean activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care. Such activities include, but are not limited to:
 - (i) Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
 - (ii) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (iii) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), and related health care data processing;
 - (iv) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
 - (v) Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services; and
 - (vi) Disclosure to consumer reporting agencies of necessary information relating to collection of premiums or reimbursement.
- (f) "Privacy Policy" shall mean the City of Farmington Health Plan HIPAA Privacy Policy.
- (g) "Protected Health Information" or "PHI" shall mean individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former participant, provision of health care to a participant, or payment for such health care; (2) can either identify the participant, or there is a reasonable basis to believe the information can be used to identify the participant; and (3) is received or created by or on behalf of a Plan.
- (h) "Responsible Employee" shall mean an employee (including a contract, temporary, or leased employee) of the Plan or of the City whose duties (1) require that the employee have access to PHI for purposes of Plan Payment or Health Care Operations, or (2) make it likely that he or she will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 3. Responsible Employee shall also include any other employee (other than a designated Responsible Employee) who creates or receives PHI on behalf of a Plan, even though his or her duties do not (or are not expected to) include creating or receiving PHI. Responsible Employees are within the City's HIPAA firewall when they perform Plan functions.

3. Responsible Employees. Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI on behalf of a Plan. The use or disclosure of PHI by Responsible Employees shall be restricted to the Plan's administration functions that the City performs on behalf of a Plan, pursuant to Section 4.

- (a) City employees who perform the following functions on behalf of a Plan are Responsible Employees:
 - (i) enrollment functions
 - (ii) eligibility and claims processing functions;
 - (iii) information systems support activities;
 - (iv) internal audit functions; and
 - (iv) law department activities.

(b) In addition to those individuals described in Subsection 3(a) above, the Plan's HIPAA privacy officer and City employees to whom the Plan's HIPAA privacy officer has delegated any of the following responsibilities shall also be Responsible Employees:

- (i) implementation, interpretation, and amendment of the Privacy Policy;
- (ii) documentation of the Plan's routine transactions involving PHI;
- (iii) approval of the disclosure of PHI to a health care provider for treatment purposes; for health and safety purposes; for legal or law enforcement purposes; for post-mortem identification or tissue donation purposes; for national security or other permitted governmental purposes; or to comply with applicable law;
- (iv) Privacy Rule training for Responsible Employees;
- (v) investigation of and response to complaints by participants and/or employees;
- (vi) preparation, maintenance, and distribution of the Plans' privacy notice;
- (vi) response to requests by participants to inspect or copy PHI;
- (vii) response to requests by participants to restrict the use or disclosure of their PHI;
- (viii) response to requests by participants to receive communications of their PHI by alternate means or in an alternate manner;
- (x) amendment of and response to requests to amend participants' PHI;
- (xi) response to requests by participants for an accounting of disclosures of their PHI;
- (xii) response to requests for information by the Department of Health and Human Services;
- (xii) approval of disclosures to law enforcement or to the military for government purposes;
- (xiv) maintenance of records and other documentation required by the Privacy Rule;
- (xv) evaluation of a third party's status as a participant's personal representative; or
- (xvi) negotiation with and oversight over business associates of the Plan.

4. Permitted Uses and Disclosures. Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of a Plan, consistent with the Privacy Policy. This includes:

- (a) uses and disclosures for the Plan's own Payment and Health Care Operations functions;
- (b) disclosures to a health care provider, as defined under 45 C.F.R. § 160.103, for the health care provider's treatment activities;
- (c) disclosures to the City, acting in its role as Plan sponsor, (1) of summary health information for purposes of obtaining health insurance coverage or premium bids for the Plan or for making decisions to modify, amend, or terminate the Plan, or (2) of enrollment or disenrollment information;
- (d) disclosures of a participant's PHI to the participant or his or her personal representative, as defined under 45 C.F.R. § 164.502(g);

- (e) disclosures to a HIPAA Health Plan for the other HIPAA Health Plan's Payment or Health Care Operations activities;
- (f) disclosures to a participant's family members or friends involved in the participant's health care or payment for the participant's health care, or to notify a participant's family in the event of an emergency or disaster relief situation;
- (g) uses and disclosures to comply with workers' compensation laws;
- (h) uses and disclosures for legal and law enforcement purposes, such as to comply with a court order;
- (i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule;
- (j) uses and disclosures for other governmental purposes, such as for national security purposes;
- (k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
- (l) uses and disclosures to identify a decedent or cause of death, or for tissue donation purposes;
- (m) uses and disclosures required by other applicable laws; and
- (n) uses and disclosures pursuant to the participant's authorization that satisfies the requirements of 45 C.F.R. § 164.508.

5. Certification Requirement. The Plan shall disclose PHI to the City only upon receipt of a certification by the City that the City agrees:

- (a) not to use or further disclose PHI other than as permitted or required by the Plan and the Privacy Policy or as required by law;
- (b) to ensure that any agents, including subcontractors, to whom the City provides PHI agree to the same restrictions and conditions that apply to the City with respect to such PHI;
- (d) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the City;
- (d) to report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures described in Section 4 of which the City becomes aware;
- (e) to make available PHI for inspection and copying in accordance with 45 § C.F.R. 164.524;
- (f) to make available PHI for amendment, and to incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- (f) to make available PHI required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (g) to make its internal practices, books, and records relating to the use and disclosure of PHI received on behalf of the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;

- (j) if feasible, to return or destroy all PHI received from the Plan that the City still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of PHI infeasible; and
- (j) to ensure that there is adequate separation between the Plan and the City's activities in its role as Plan sponsor and employer.

6. Mitigation. In the event of non-compliance with any of these provisions, the Plan's HIPAA privacy officer shall address any complaint promptly and confidentially.

- (a) The privacy officer first will investigate the complaint and document his or her investigation efforts and findings.
- (b) If PHI has been used or disclosed in violation of the Privacy Policy or inconsistent with these provisions, the privacy officer shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.
- (c) If a Responsible Employee or other City employee is found to have violated the Privacy Policy, such personnel shall be subject to disciplinary action up to and including termination."

* * *

BE IT FURTHER RESOLVED, that the City agrees to the obligations and restrictions set forth in Section 5 above.

FEDERAL CONTINUATION COVERAGE

(also known as COBRA)

In some circumstances, federal law requires that persons who lose group health plan coverage be given the chance to continue that coverage for a period of time.

Right to COBRA Continuation Coverage

1. You have a right to choose COBRA continuation coverage if You lose group health plan coverage because of:
 - a. a reduction in Your hours of employment; or
 - b. the voluntary or involuntary termination of Your employment (for any reason except Your gross misconduct).
2. Your spouse has the right to choose COBRA continuation coverage if he/she loses group health plan coverage for any of the following reasons:
 - a. Your death;
 - b. the termination of Your employment (except as a result of Your gross misconduct) or Your reduction in hours;
 - c. Your divorce or legal separation;
 - d. Your becoming entitled to Medicare.
3. Your dependent Child has the right to continuation coverage if he/she loses his/her group health plan coverage due to one of the four reasons described in 2. above or if he/she ceases to be an Eligible Dependent under the terms of the Plan's Health Care coverage.

A dependent child born to or placed for adoption with You during Your COBRA continuation coverage period has the right to COBRA continuation coverage if You notify the plan administrator of the child's birth or placement for adoption within the time frame as prescribed by law.

Length of COBRA Continuation Coverage

1. Generally
 - a. If, as a result of termination of Your employment or reduction in Your hours, You, Your spouse and/or Your dependents lose the Plan's Health Care coverage, those who do lose coverage may elect continuation coverage for up to **18 months** after the date Your employment terminates or hours reduce.
 - b. If Your spouse or dependents lose the Plan's Health Care coverage due to any of the other events described in 2. or 3. above (other than Your employment termination or hours reduction), they may elect continuation coverage for up to **36 months** from the date they experience such event.
 - c. If Your spouse or dependents become entitled to continuation coverage because of termination of Your employment or reduction in Your hours and Your spouse or dependent then experiences another of the events which would entitle such person to continued coverage, he/she may extend the 18 month continuation period to **36 months** from the date of the event that first made him/her eligible for continuation coverage.

FEDERAL CONTINUATION COVERAGE - Continued

2. Extensions of COBRA Continuation Coverage
 - a. Disability Extension

If You, Your spouse or Your dependents lose coverage because of termination of Your employment or reduction of hours and any of You are determined under Title II or XVI of the Social Security Act to have been Disabled at any time during the first 60 days of COBRA continuation coverage, then the Disabled person and such person's family members who are entitled to COBRA continuation coverage may extend the continuation coverage period for **11 additional months**, provided:

A notice of a Social Security determination is given to the plan administrator before the end of the initial 18-month period and within 60 days after the date of such determination.

An Employer may require payments of up to 150 percent of the applicable group rate for the cost of coverage for these 11 additional months.

- b. Employee's Medicare Entitlement Prior to COBRA Event

If You become entitled to Medicare within 18 months prior to Your employment termination (or work hours reduction), Your spouse and dependents who are entitled to COBRA continuation coverage will become eligible for a continuation period of not shorter than 36 months from the date You become entitled to Medicare. This continuation period is measured from the time You are entitled to Medicare. The maximum continuation period for Your spouse or dependents will not exceed 36 months.

However, unless You are entitled to an extended continuation period as described in 2.a. above, You yourself will only be eligible for a continuation period of up to 18 months from the date of Your employment termination (or work hours reduction).

3. If, after the occurrence of any event described in Right to COBRA Continuation Coverage above, You, Your spouse and/or Your dependents are allowed to continue Health Care coverage under the Plan (whether or not premium payment(s) are required) beyond the Plan's Termination of Coverage provision for any reason other than to comply with the federal law (i.e., the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this section.

Notification Requirements

1. If Your spouse or dependent becomes eligible for continuation coverage due to divorce, legal separation or the end of dependency status, the Plan Administrator must be notified within 60 days after Your spouse or dependent becomes eligible. That person will distribute necessary forms and explain this continuation in more detail.

If the Plan Administrator is not notified within 60 days of the event that makes Your spouse or dependent eligible for continuation coverage, Your spouse or dependent will lose the right to such coverage.

In order for a child born to or placed for adoption with You during Your COBRA continuation coverage to have the right to COBRA continuation coverage, You must notify the plan administrator of the child's birth or placement for adoption within the time frame as prescribed by law.

FEDERAL CONTINUATION COVERAGE - Continued

2. In order for a Disabled person and such person's family members continuing under the 18-month continuation coverage to be entitled to an extended continuation period of 11 additional months, such person must meet the notice requirements and all other conditions described under Extensions of Continuation Coverage in 2.a. above.

A person continuing under the 11-month extended continuation coverage must notify the Plan Administrator within 30 days if the Social Security Administration determines that the disability ceases to exist.

Termination of COBRA Continuation Coverage

Your Employer may require You, Your spouse and Your dependents to pay for the cost of the continuation coverage. If these amounts are not paid within the time allowed, the continuation coverage will end.

Four other reasons that this continuation coverage may terminate before the full maximum continuation period runs out are:

1. the continued person first becomes, after the date of COBRA continuation coverage election, entitled to Medicare benefits (except for a person whose COBRA continuation right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code);
2. the Employer stops providing any group health plan benefits program for employees;
3. the continued person first becomes, after the date of COBRA continuation coverage election, covered under another group health plan, and any preexisting conditions exclusions or limitations of that plan do not apply to or are satisfied by such person;
4. with respect to any person continuing under the 11-month extended continuation coverage (as described under Extensions of Continuation Coverage in 2.a. above), when the Social Security Administration determines that the disability ceases to exist (the termination becomes effective as of the first day of the month which is at least 31 days after the Social Security determination).

General Information

This Federal Continuation Coverage section does not amend or change the Plan's Termination of Coverage provision. It simply provides a continuation of coverage right Your Employer is required to offer by law.