

***Plan Document and
Summary Plan Description for the
The Macon County Employee Benefit Plan***

- Medical and Prescription Drug Benefits
- Dental Benefits

Amended and Restated: 07/01/2014

Introduction

Macon County (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, dental benefits and serves as the Summary Plan Description (SPD) and Plan document for the Macon County employee Health and Welfare Benefit Plan (“the Plan”).

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act (“ERISA”) of 1974, as amended.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

Macon County believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (“Affordable Care Act”). As permitted under the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provisions of preventive health care services without any cost sharing. However, grandfathered plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: Macon County, 5 West Main Street Franklin, NC, 28734, 828-349-2026.

You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

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Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- A part-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company;
- An eligible Retired Employee of the Employer;
- An elected county official (commissioner);
- An Employee who had prior coverage under the Plan and who returns to active service following an approved, unpaid leave of absence and who did not continue coverage during such absence, will be considered eligible to participate in the Plan and will be subject to 12 months of pre-existing condition limitation. Coverage will be effective as of the first day of the Calendar month following 30 days.
- In a class of employees eligible for coverage.
- The following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.
- as a member of the group regardless of age, or until the retiree ceases to be eligible as a retired employee as specified under the Group's Retirement Program.

Retired Employee/Spouse Eligibility

Retired Employees who were hired prior to July 1st, 2014 and meet the following requirements will be considered eligible to participate in the plan according to the subsequent years of service:

- Retirees with less than 15 years in the State system are not eligible to participate in the Plan.
- Retirees with at least 15 years but less than 25 years in the State retirement system will be considered eligible to participate in the Plan until he or she becomes eligible for Medicare. Spouses are not eligible.
- Retirees with at least 25 years in the State retirement system will be considered eligible to have lifetime participation in the Plan. Upon Medicare eligibility, the Plan will become secondary to Medicare. Spouses are not eligible.
- Effective July 1, 2006, Retirees with at least 30 years in the State retirement system will be considered to have lifetime participation in the Plan. Eligible spouse will be allowed to participate as long as the Retiree remains eligible.

Retired Employees who were hired or rehired on or after July 1st, 2014 and meet the following requirements will be considered eligible to participate in the plan:

- Employees who are members of the group health plan and retire with a minimum of 30 years of service as determined by the North Carolina Local Government Retirement System (LGERS) and who are qualified to receive service retirement from LGERS will be eligible to continue as a member of the group regardless of age, or until the retiree ceases to be eligible as a retired employee as specified under the Group's Retirement Program. The spouse of an eligible employee will not be allowed to participate.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse (as determined by state law);
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; or
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a step child who resides in the Employee's household as long as you are married to the child's natural parent;
- a foster child residing in your household;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does *not* include:

- a person enrolled as an employee under the Plan;
- any person who is in active military services;
- a former Spouse; or
- a person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you. It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Company reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

When Coverage Begins

For You

Your health care coverage begins First day of the calendar month following 30 consecutive days as an active employee and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan. However, if you return to work and were enrolled in COBRA Continuation Coverage immediately prior to your rehire date, you will be covered under the Plan as of your rehire date.

For Your Dependents

If you enroll your eligible dependents within 31 days of your initial eligibility, their coverage begins at the same time as yours.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next annual open enrollment period.

A newborn child born while you are enrolled for medical coverage will not automatically be enrolled in the Plan. Coverage will be effective with the newborn's date of birth, provided the child is enrolled within 31 days of birth. A separate annual deductible and coinsurance will apply to charges incurred by the newborn child.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug and/or dental coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next June 30, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverage's designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a "late entrant" if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Coverage begins the first of the month following enrollment.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following July 1 and stay in effect through June 30, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a change in your Company work location or home address that changes your overall benefit options and/or prices;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee, unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage or becomes eligible for coverage under another employer's plan. However, for a dependent child who reaches limiting age, coverage ends on the last day of the month in which the child reaches the limiting age.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the date you request termination of coverage for you and your covered dependents. Coverage will also end as of the date you or a covered dependent has a claim denied due to exceeding a maximum benefit, if applicable, under the Plan.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made

by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits, paid as a result of the wrongful activity, that are in excess of the premiums paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence – FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the Company's FMLA Policy.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

Benefits are provided through a Preferred Provider Organization, or “PPO”.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Summary of Medical Benefits chart below for more information.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the Claims Administrator for the network shown on your ID card.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or Claims Administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the reasonable and customary limit or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. See the Summary of Medical Benefits chart below for additional information.

However, if you travel into an area that offers an in-network provider, and you choose not to use the in-network provider, then all services will be covered at the out-of-network level of benefits as described above.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis.

Consult the Summary of Medical Benefits chart for more information. Your medical deductible does not include:

- co-payments
- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

Deductible Accumulation

Each individual must meet the individual deductible before benefits are payable unless the family deductible is satisfied by one or more individuals, which will then satisfy the family deductible.

Both in-network and out-of-network charges will apply to the deductible amount.

Your Co-payment

Once you meet the deductible, some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. This amount applies regardless of whether the deductible has been satisfied. Any co-payments will be shown in the Summary of Medical Benefits Chart below.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. The Summary of Medical Benefits chart below shows the coinsurance levels for common medical services in-network and out-of-network.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay. It is calculated on a calendar year basis. When your share of coinsurance for covered medical expenses reaches the out-of-pocket maximum, your coinsurance percentage becomes zero for the rest of the year – and the Plan pays 100% of covered medical expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts.

Your out-of-pocket maximum does not include:

- your deductible
- co-payments
- amounts over UCR
- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

The out-of-pocket maximum also excludes Services related to the treatment of obesity.

Out-of-Pocket Accumulation

Each individual must meet the individual out-of-pocket maximum before benefits are payable unless the family out-of-pocket maximum is satisfied by one or more individuals, which will then satisfy the family deductible.

Both in-network and out-of-network charges will apply to the out-of-pocket maximum.

Maximum Allowed Amount (Reasonable/Usual and Customary Limits)

If you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Summary of Medical Benefits

	In-Network	Out-of-Network
Annual Maximum (per participant [all services combined])	No Maximum	No Maximum
Annual Deductible (applies to expenses below unless otherwise noted)	\$500 / individual \$1,000 / family	\$1,000 / individual \$2,000 / family
Annual Out-of-Pocket Maximum (includes covered expenses under the Plan)	\$1,500 / individual \$3,000 / family	\$5,000 / individual \$10,000 / family

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Allergy Shots	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Ambulance Service	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Ambulatory Surgical Center	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Anesthetics, Oxygen, Transfusions	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Chemotherapy	Plan pays 90% (after deductible)	Plan pays 70% (after deductible)
Chiropractic Care Limited to 30 visits per calendar year Maximum paid benefit of \$50 per visit (does not include x-rays)	Plan pays 80% (after deductible)	Plan pays 80% (after deductible)

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Diagnostic X-rays and Lab Services (includes advanced radiological imaging)		
Performed in and billed by a physician's office (Deductible does not apply In-Network)	Plan pays 100% (after \$25 PCP copay or \$50 Specialist copay)	Plan pays 80% (after deductible)
Performed in and billed by an inpatient or outpatient lab/facility without office visit.	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Durable Medical Equipment	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Emergency/Acute Care Hospital ER Room (Deductible does not apply. Copay is waived if admitted)	Plan pays 100% (after \$150 copay)	Plan pays 100% (after \$150 copay)
Urgent Care Facility (Deductible does not apply In-Network)	Plan pays 100% (after \$50 copay)	Plan pays 80% (after deductible)
Hemodialysis	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Home Health Care Limited to 60 visits per calendar year Precertification required.	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Hospice Care Precertification required.	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Hospital Services – Inpatient Requires precertification Pregnancy listed below	Plan pays 90% (after deductible)	Plan pays 80% (after deductible and a \$250 copay per confinement)
Hospital Services – Outpatient	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Infertility Treatment (includes services for the diagnosis and treatment to restore fertility up to a lifetime maximum of \$10,000)	Plan pays 50% (after deductible)	Plan pays 50% (after deductible)
Jaw joint/TMJ Subject to a \$1,000 Lifetime Maximum	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions. Precertification required for extended stay only.		
Inpatient hospital services or birthing center including labor and delivery.	Plan pays 90% (after deductible)	Plan pays 70% (after deductible and a \$250 copay per confinement)
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Mental Health and Substance Abuse Treatment		
Doctor's office visits	Plan pays 100% (after \$25 copay)	Plan pays 80% (after \$50 copay)
Outpatient/Intermediate Care	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Inpatient Care Precertification required	Plan pays 90% (after deductible)	Plan pays 80% (after deductible and a \$250 copay per confinement)
Newborn Care – Inpatient	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Private Duty Nursing Limited to 60 visits per calendar year	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Primary Care Physician - Office visit for injury or sickness (excludes preventive care) (Deductible does not apply)	Plan pays 100% (after \$25 copay)	Plan pays 80% (after \$50 copay)
Specialist Physician – Office visit for injury or sickness (excludes preventive care) (Deductible does not apply In-Network)	Plan pays 100% (after \$50 copay)	Plan pays 80% (after deductible)
Prosthetics	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Radiation Therapy	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Reconstructive Surgery	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Routine Preventive Care/Wellness Benefits - Maximum paid benefit of \$400 per participant per calendar year coinsurance and deductible apply to amounts in excess of limit. Deductible does not apply if in-network.		
Routine periodic and screening exams	Plan pays 100% (after \$25 copay)	Plan pays 80% (after \$50 copay)
Routine gynecological exam/Pap smear	Plan pays 100% (after \$25 copay)	Plan pays 80% (after \$50 copay)
Well-baby/Well-child Care	Plan pays 100% (after \$25 copay)	Plan pays 80% (after \$50 copay)
Immunizations and Flu Shots (Only eligible when performed at the Health Department)	Plan pays 100% (no copay applies)	N/A
Routine Colonoscopy	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Mammogram (not subject to the \$400 preventive limit)	Plan pays 100%	Plan pays 80% (after \$50 copay)
Second Surgical Opinions – voluntary	Plan pays 100% (after \$25 PCP copay or \$50 Specialist copay)	Plan pays 80% (after \$50 copay)
Skilled Nursing Facility Limit of 60 days per calendar year (combined in- and out-of-network)	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Sterilization Procedures	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)
Surgery		
Hospital Inpatient Precertification required.	Plan pays 90% (after deductible)	Plan pays 80% (after deductible and a \$250 copay per confinement)
Outpatient Facility Precertification required.	Plan pays 90% (after deductible)	Plan pays 80% (after deductible)

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Therapy Services - Performed in and billed by Physician's office or at outpatient facility or inpatient. Therapy limited to combined maximum visits of 30 per plan year for occupational, physical, speech, and cardiac rehabilitation therapies and are combined in- and out-of-network.		
Cardiac Rehabilitation Therapy Precertification required	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Occupational Therapy Precertification required	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Physical Therapy Precertification required	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Pulmonary/Respiratory Therapy Precertification required	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Speech Therapy Precertification required	Plan pays 80% (after deductible)	Plan pays 70% (after deductible)
Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury).		

* A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.

NOTE: Lifetime maximum limits on non-essential benefits may still apply to certain benefits under the Plan, as permitted under PPACA. No lifetime limits may be applied to "essential benefits", as such term is defined under PPACA and regulations thereunder.

Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above). The following are common conditions and services for which expenses are typically paid:

- **Abortion** – includes charges for non-elective abortions. Covered only if the life of the mother is endangered by the continued pregnancy; the pregnancy was the result of rape or incest;
- **Allergy testing and treatment** – includes allergy testing, serum and injections as shown above;

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- **Ambulance** – includes medically necessary professional ambulance services. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was medically necessary. Includes charges for local ground or air transportation by a professional ambulance service.
 - **Ambulatory Surgical Center** – includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
 - **Amniocentesis** – see Pregnancy
 - **Anesthesia** – includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.)
 - **Birthing Center** – includes services and supplies provided by a licensed Birthing Center in connection with a covered pregnancy.
 - **Blood** – includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services. Also includes processing, storage, and administration charges for autologous blood (patient's own blood) when a covered person is scheduled for surgery that can be expected to require blood.
 - **Cardiac Rehabilitation** – see Therapy, Short-Term
 - **Chemical Dependency** – see Substance Abuse
 - **Chemotherapy** – includes medically necessary and appropriate drugs and services of a physician or medical provider; also includes initial purchase of a wig following chemotherapy.
 - **Chiropractic Care** – includes musculoskeletal manipulation by a licensed physician (M.D. or D.O.) or chiropractor (D.C.) to correct vertebral and/or joint related disorders, such as incomplete dislocation, misalignment, sprain or strain.
 - **Circumcision**
 - **Counseling**
 - **Diagnostic Lab and X-Ray, Outpatient** – includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; also includes advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests;
 - **Durable Medical Equipment** – includes coverage for the rental (or purchase, if rental would be more costly) of durable medical equipment (including wheelchairs) required for therapeutic purposes, as prescribed by a covered provider and determined by the Plan to be medically necessary.
 - **Emergency Room Visits** – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

Colds, sore throats, flu, and infections are examples of nonemergencies, although they may require urgent treatment.

- **Hemodialysis Services** – includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **Home Health Care/Nursing** – includes home visits by a staff member of a home health care or private duty nursing agency (including a person under contract or arrangement with the agency), or a licensed therapist, during which any of the following services are provided:
 - Part-time or temporary nursing care performed by an R.N. or a licensed practical nurse (L.P.N.)
 - Part-time or temporary care by a home health aide
 - Physical, occupational, speech, or respiratory therapy
 - Oxygen service

To be covered, home health care must be provided according to a home health care program set up in writing by a doctor. The doctor must state that the patient is, for all practical purposes, confined at home and the medical condition requires home health care.

To be covered, the home health care agency must:

- meet standards set by Medicare;
- be approved by the Plan; and
- be approved by your area's health care planning agency (if applicable).

Contact the Plan for approval before arranging home health care services.

- **Hospice Care** – includes hospice services furnished to a terminally ill person after the date the person enters the hospice care program. Also includes bereavement counseling services incurred before the patient's death for the patient and for covered members of the immediate family within 6 months of the patient's death.

To be covered, the hospice care program must:

- meet standards set by the National Hospice Organization;
- be approved by the Plan;
- be Medicare approved; and
- be directed by a doctor.

If the program is required to be state licensed, certified, or registered, it also must meet that requirement. Contact the Plan for approval before arranging hospice care services.

- **Hospital Services** – include hospital charges for the following:
 - Room and board - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only

hospital, the full cost of the private room will be considered a covered medical expense.

- services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
- services of nursing staff and other hospital staff providing care;
- emergency room services; and
- medically necessary services.

An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Infertility Diagnosis and Treatment** – includes services and treatment for infertility (including diagnosis) up to a lifetime limit of \$10,000.
- **Medical Supplies** – includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines** – includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Health** – coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- **Midwife** – includes services of a certified or registered nurse midwife when provided in conjunction with a covered pregnancy.
- **Newborn Care** – includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births.

Services for a newborn child are covered only if the child is enrolled in coverage within 31 days of birth.

- **Obesity** - includes gastrointestinal surgeries for morbidly obese patients who meet specific criteria. All services are paid at 50% after the deductible and are subject to a Maximum paid benefit of \$30,000.
- **Occupational Therapy** – see Therapy, Short-Term
- **Oral Surgery/Dental Care** – includes oral surgery for the following procedures:
 - removal of tumors and cysts of the jaws, cheeks, lips, tongue, roof or floor of the mouth
 - removal of impacted teeth
 - repairs to sound natural teeth, jaws, cheeks, lips, tongue, floor or roof of the mouth due to an accident or injury

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- excision of benign bony growths of the jaw or hard palate
 - incision of sensory sinuses or salivary glands ducts
 - external incision and drainage of cellulitis
 - jawjoint conditions including Temporomandibular Joint syndrome (TMJ)
- **Organ and Tissue Transplants** – If you or a covered dependent faces a potential transplant, contact the Plan as soon as possible to determine the benefits available to you.

Benefits include charges incurred for the care and treatment related to an approved transplant of an organ or tissue. There is no coverage for evaluation, removal from the donor and/or transportation of the organ or tissue.

If the transplant recipient is covered by the Plan, benefits will be provided only when the hospital and physician customarily charge a recipient for such care and services. No benefits will be payable for services for which a participant would not be legally obligated to pay if there were no coverage under the Plan.
 - **Orthotics** – includes orthopedic braces, casts, splints, trusses and other orthotics prescribed by a physician that are required for support of an injured or deformed part of the body as a result of a congenital condition or an accidental injury and medically necessary foot orthotics.
 - **Podiatry** – includes treatment for bunions (when an open cutting operation is performed); toenails when at least part of the nail root is removed; or any required medically necessary surgical procedure on the foot. Excludes coverage for routine foot care or treatment of unstable or flat feet.
 - **Pregnancy** – includes prenatal visits and routine pre- and post-partum care, routine ultrasounds, amniocentesis tests for genetic testing, hospital stays, or birthing center, and obstetric services provided by a doctor or certified nurse-midwife (working under the direction of a doctor) for pregnancy, childbirth, or related complications for you and your covered spouse only.

Maternity benefits may be provided even if the pregnancy began before covered under the Plan, as long as coverage is in effect when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid.

Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours.
 - **Private Duty Nursing** – provided inpatient only when care is medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit. Provided in conjunction with approved home health care (see above).
 - **Prosthetics** – includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have

been lost due to an accidental injury, sickness or surgery. Also includes replacement of a prosthetic device due to a change in the patient's physical condition that makes the original device no longer functional.

To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.

- **Radiation Therapy** – includes radium and radioactive isotope therapy.
- **Reconstructive Surgery** – includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

Coverage also includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; also includes surgery required to repair a congenital absence or agenesis (lack of formation or development) of a body part.

- **Respiratory/Pulmonary Therapy** – see Therapy, Short-Term
- **Routine Preventive Care/Wellness Benefits** – covers routine preventive care that includes, but is not limited to:
 - routine physicals, in accordance with American Medical Association age-based guidelines, which include medical history, physical exam, prostate exam, proctosigmoidoscopic exam, x-rays, laboratory tests, weight/height, blood pressure, cholesterol screening, urinalysis, blood glucose, bone density scans, Gardisal injections and contraceptive management and EKG, as medically appropriate;
 - routine gynecological exam and Pap smear;
 - a mammogram provided in accordance with age-based guidelines unless medically necessary;
 - well baby/well child care provided for children through age 19; and
 - immunizations and flu shots administered at the health department only except immunizations for the sole purpose of travel outside the U.S.

Recommended services and procedures can be found under the Prevention & Wellness tab at www.healthcare.gov.

- **Second Surgical Opinions** – covers a second (or third) surgical opinion you voluntarily obtain before recommended surgery. Second opinions provide you with more information so that you can make an informed decision about whether to have surgery or follow another course of treatment.
- **Skilled Nursing/Sub-Acute Facility** – includes room and board and non-custodial nursing care provided under the treatment plan of a physician if the patient is confined as a patient in the facility. The confinement must begin within 14 days of a hospital stay when the physician certifies that further care is needed and must be for the same condition for which the patient was hospitalized.

- **Sleep Disorders** – includes services, supplies, medications, and testing related to the diagnosis and treatment of sleep disorders, such as insomnia, narcolepsy, sleep apnea, and parasomnias. Excludes sleep therapy treatments designed to modify behaviors or sleep habits.
- **Smoking Cessation** – includes expenses for smoking cessation program only when medically necessary due to a severe active lung illness such as emphysema or asthma.
- **Speech Therapy** – see Therapy, Short-Term
- **Sterilization** – includes voluntary sterilization procedures for employee and covered spouse only. Excludes reverse sterilization procedures.
- **Substance Abuse** – includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.
- **Surgery** – includes surgeries performed in a doctor's office, outpatient facility or hospital. However, payments for multiple surgical procedures or surgeries involving more than one surgeon or assistant will be paid based on the primary procedure and the number of procedures and individuals involved. Payments for assistant surgeons may be limited as well. Any procedure not integral to the primary procedure or unrelated to the diagnosis will not be covered.

When an assistant surgeon is required to render technical assistance during an operation, the eligible covered expense will be limited to 20 percent of the covered expense for the surgical procedure.

If multiple surgeries are performed at the same time by one surgeon, the eligible covered expense is the fee for the major procedure plus 50 percent of the R&C charge for additional procedures performed through the same incision.

If multiple unrelated surgical procedures are performed by two or more surgeons, benefits will be based on the R&C charge for each surgeon's primary procedure. If two or more surgeons perform a surgery normally performed by one surgeon, benefits for all surgeons will not exceed the R&C charges allowed for the procedure.

- **Therapy, Short-Term** – includes the following rehabilitation therapy services provided on an outpatient basis:
 - Cardiac Rehabilitation Therapy – includes services provided under the supervision of a physician in an approved facility in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery, in order to restore physiological and psychological well-being to an individual with heart disease. Must be initiated within 12 weeks after other treatment for the medical condition ends.
 - Physical Therapy – Includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.

- Occupational Therapy - includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function;
- Pulmonary/Respiratory Therapy – includes services of a licensed respiratory or inhalation therapist, when prescribed by a physician as to type and duration for function improvement of chronic respiratory impairment;
- Speech Therapy – Includes services of a licensed speech therapist when prescribed by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or sickness (other than a learning or mental disorder);

Maintenance care is not covered under any category above.

- **TMJ / Jaw Joint Treatment** - includes medically necessary treatment of jaw joint problems such as temporomandibular joint syndrome and cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint. Maximum paid lifetime benefit of \$1,000.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

Alternative Treatments

- music therapy;
- massage therapy;
- charges for pain disorder services or treatment including, but not limited to biofeedback, aversion therapy, self-help programs, services rendered by a masseur/masseuse, health club membership fees, or any similar type program designed for pain disorders such as ultrasound-guided extracorporeal shock wave therapy;
- acupuncture or acupressure treatments unless administered by a licensed physician;

Comfort/Convenience Items and Services

- custodial care/assistance with activities of daily living, whether in a residential care facility, skilled nursing facility, or at home, including help in walking, bathing, preparing meals and special diets, and supervising use of medication;
- personal convenience items or equipment including, but not limited to, radio/television rentals, air conditioners, humidifiers, air purification or heating

units, exercise equipment, elastic bandages or stockings, non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines;

Dental/Oral

- orthodontic treatments;

Podiatry/Foot Care

- Charges for examinations or fittings for routine care and treatment;

Medical Supplies/Appliances

Counseling

- Diabetes and Nutritional Education;
- services of dieticians and/or nutritionists and nutrition programs;
- educational or vocational testing;
- ancillary services for learning disabilities or developmental delays;

Physical Appearance

- services for cosmetic reasons, except for covered reconstructive surgery;
- breast reduction surgery;
- expenses related to the care and treatment of hair loss (excluding wigs after chemotherapy if indicated under eligible expenses above);
- services, supplies or treatment of weight reduction (except for morbidly obese as described above)

Reproduction/Sexual

- services, supplies, or treatment for transsexualism, gender dysphoria, or sexual assignment or change, including medications, implants, hormone therapy, surgery, or medical or psychiatric treatment;
- treatment of benign gynecomastia;
- dependent pregnancies;
- sterilization reversals;
- fertility treatments (except as provided under Eligible expenses above);
- diagnosis, care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity not related to organic disease (except as may be covered under the Prescription Drug benefit);
- genetic testing;

Services Provided by Another Plan

- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan;
- services for any condition, illness, or injury, or complication thereof arising out of or in the course of employment, when the participant or covered dependent is furnished care or services covered hereunder, or could or might have been furnished such care and services if pursued or sought, according to the

provisions of any Worker's Compensation or occupational disease law, or any other law or regulation of the United States, or of a state, territory or subdivision thereof, or under any policy of Worker's Compensation or occupational disease insurance, or according to any recognized legal remedy available to the participant or covered dependent;

Travel-Related Expenses

- travel and accommodation expenses unless provided above under the Plan for a particular service;
- expenses for care or treatment outside of the United States if travel was for the sole purpose of obtaining medical services;

Hospital/Hospice Services

- any hospital stay that is not for the diagnosis or treatment of a sickness or injury;
- non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission;
- complications resulting from non-covered services (other than abortion);

Home Services/Nursing

- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living;
- respite care;

Vision/Hearing

- hearing exams, hearing aids including related services or supplies or fitting exams except as may be covered under wellness benefits;
- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation or the special contacts necessary to treat keratoconus; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages except as may be covered under wellness benefits;
- expenses for radial keratotomy or any other surgery to correct nearsightedness or refractive errors;

Non-Compliance

- all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice;

Behavioral Exclusions

- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation or activity, assault, or felonious behavior or activity; this exclusion does not apply to an injury or sickness contracted as the result of domestic violence or a medical (both physical or mental) condition;

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- services or expenses to treat an intentionally self-inflicted injury while sane or insane; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical or mental) condition;
 - services, supplies, care, or treatment for an injury or sickness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm such as (but not limited to) skydiving, auto or powerboat racing, hang gliding, jet ski operating, rock climbing, or bungee or base jumping;
 - services, supplies, care or treatment resulting from a participant's or covered dependent's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition);
 - services, supplies, care or treatment resulting from a participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition);
 - services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a serious illegal act which includes any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction results, or that a sentence for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required (does not apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);
 - charges for failure to keep a scheduled visit, telephone consultations between patient and doctor, or completion of claim forms;
 - services, supplies, care, or treatment for an injury or sickness which occurred as the result of or was caused by engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance (does apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);

All Other

- expenses resulting from complications of a treatment not covered by the Plan (other than abortion);
- services rendered by an unlicensed provider;

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- services or supplies for sickness, defect, disease, or injury due to war or a warlike action in time of peace;
 - services or supplies that are experimental or investigational;
 - services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
 - any charges in excess of the maximum amount payable under the Plan for a particular service or supply (see “Maximum Allowed Amount” above);
 - autopsies;
 - services or supplies received before the patient is covered by the Plan;
 - services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
 - services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate care for the injury or sickness; and
 - services performed by a person who ordinarily resides in the participant’s home or who is related to the participant and/or his covered dependents as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization (and certain other treatments) as shown in the Summary of Medical Benefits above. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed on the back of your ID card to precertify an admission or treatment:

- at least 8 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Procedures requiring Precertification

Please see Appendix A for a list of procedures requiring precertification.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. If/when the pregnancy confinement for the mother or newborn is expected to exceed these limits, precertification for such extended confinement is required.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by \$500. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan's appeal process.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;
- coma;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitating disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.caremark.com.

Coverage Categories and Your Co-payment

There are three tiers in the prescription drug Plan; each has a different co-payment that applies depending on where you have your prescription filled. The chart below shows your co-payment amounts, co-payment maximum out-of-pocket amounts, and any deductible. If your Plan has a deductible, you must satisfy the deductible before the Plan pays benefits.

Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. The co-payment for generic drugs is \$10 per prescription for up to a 30-day supply. For generic drugs purchased through the mail service program, the co-payment is \$20 per prescription for up to a 90-day supply.

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category. Your co-payment for formulary (brand-name) drugs at a network retail pharmacy is \$35 per prescription for up to a 30-day supply. For formulary drugs purchased through the mail service program, the co-payment is \$70 per prescription for up to a 90-day supply.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug alternatives are available. Your co-payment for non-formulary drugs at a network retail

pharmacy is \$50 per prescription for up to a 30-day supply. For non-formulary drugs purchased through the mail service program, the co-payment is \$100 per prescription for up to a 90-day supply.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. You will receive a prescription drug identification (ID) card from the Claims Administrator. Present this card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can also be conveniently refilled by phone or by using Pharmacy Manager’s Web site www.caremark.com.

Your Prescription Drug Coverage

	In-Network Retail Pharmacy (up to a 30-day supply)	Mail-Service Program (up to a 90-day supply)
	Co-Pay	Co-Pay
Generic	\$10	\$20
Preferred Brand Name	\$35	\$70
Non-Preferred Brand Name	\$50	\$100
Diabetic Supplies	80%	80%

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- Alcohol swabs, when needed for injectable medicines;
- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Adapalene (Differin); (Prior authorization required)
- Prescription prenatal vitamins;
- Pigmenting and depigmenting agents;
- Drugs to treat narcolepsy including Provigil; (Prior authorization required)
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin);
- Vitamins and dietary supplements that require a prescription;
- Oral contraceptives, injectable contraceptives, and contraceptive devices (e.g., IUDs and diaphragms);
- All dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum);
- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational.

Expenses Not Covered

The following drugs and supplies, among others, are not covered under the Plan:

- Any prescription refilled in excess of the number specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- Drugs or supplies covered under Workers' Compensation or occupational disease law or any similar law;
- Drugs labeled "Caution—limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Medication administered in a doctor's office or health care facility (other than contraceptive-related medications);
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- Fertility drugs;
- Impotency drugs;

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- Norplant contraception;
 - Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);
 - Drugs for weight loss;
 - Immunization agents or biological sera;
 - Injectable Supplies (other than for Insulin);
 - Anti-Wrinkling Agents (e.g., Renova);
 - Drugs used for treatments that are cosmetic-related;
 - Over-the-counter drugs and products unless specifically listed as covered expenses in the plan;
 - Drugs used for treatments that are cosmetic-related;
 - Immunization agents or biological sera;
 - Injectable Supplies (other than for Insulin).

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the Claims Administrator at the number listed on the back of your ID card.

Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as “creditable coverage”. Since the Plan’s coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

Your Dental Benefits

The Plan provides dental benefits that cover services you receive from a licensed dentist. The Summary of Dental Benefits chart below shows the covered services under the Plan.

A dental charge is incurred on the date the service or supply is performed or furnished. However, there are times when one overall charge may be made for all or part of a treatment. In this case, the total charge will be apportioned to each separate visit or treatment. The pro-rata charge will be considered incurred as each visit or treatment is completed.

Annual Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is \$50 per person (waived for Type I services) per Calendar year. The dental deductible is separate from any other deductible that may apply under the Plan. If a member changes from the Enhanced Plan option to the Basic Plan option (or vice versa) during the open enrollment period with a July 1st effective date, any accumulation towards the deductible or plan maximums will transfer to the new plan as well.

Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. Your coinsurance is determined by the type of service you receive as shown in the chart below.

Maximum Benefit

The maximum annual benefit is \$1,000 per person per calendar year. There is also a separate individual maximum benefit of \$1,000 per lifetime for orthodontia treatment.

Covered Services

In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.

A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the Claims Administrator shown on your ID card.

Predetermination of Benefits

Before starting a dental treatment for which the charge is expected to be \$300 or more, you must obtain a predetermination of benefits using a dental claim form. The completed form should be sent to the Claims Administrator who will notify your dentist of the benefits payable under the Plan. If a predetermination of benefits is not submitted, the Plan will make a determination of benefits payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice.

Alternative Treatment

Many dental conditions can be treated in more than one way. The Plan has an alternate treatment provision which governs the maximum amount of benefits the Plan will pay for a particular treatment. If you or a covered dependent choose a more expensive treatment than is needed to correct a dental problem, based on accepted standards of dental practice, the benefit payable will be based on the cost of the treatment which would provide satisfactory results at the most cost-effective level.

Orthodontic Benefits

All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. Before starting an orthodontic treatment for which the charge is expected to be \$300 or more, you must obtain a predetermination of benefits using a dental claim form. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in accordance with the approved treatment plan over a period of up to 8 calendar quarters.

Summary of Benefits for the Enhanced Dental Plan Option

Annual Maximum Benefit (per calendar year)	\$1,000 per person
Annual Deductible (per calendar year)	\$50
Orthodontia Maximum Benefit (per lifetime)	\$1,000 per person

Diagnostic and Preventive Care (Type I) Services (No waiting period)	Plan Pays
Oral exams (limited to 2 per 12 month period)	100%
Bite-wing X-Rays (limited to 1 per 12 month period)	100%
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per 12 month period)	100%
Topical fluoride application (limited to 1 per 12 month period)	100%

Therapeutic and Restorative (Type II) Services (No waiting period)	Plan Pays
Full mouth x-rays (limited to 1 per 1 in 36 months)	80%
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Topical application of sealants on permanent molars (limit 1 per 36 month period) (limited to dependent children under age 16)	80%
Space maintainers and their fitting (limit 1 per calendar year) (limited to dependent children under age 19)	80%
Extraction of teeth, complex oral surgery, and treatment of fractures/dislocations of the jaw (excluding charges for removal of stitches or post-operative exams)	80%

Therapeutic and Restorative (Type II) Services (No waiting period)	Plan Pays
Emergency palliative treatment to relieve pain	80%
General anesthetics/administration in connection with oral surgery, fractures, and other Type II covered services.	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Consultations with a specialist	80%

Major and Prosthodontic (Type III) Services (12 Month waiting period*)	Plan Pays
Periodontics (treatment of the gums and support structures of the teeth)	50%
Root canals, implants and other endodontic treatments	50%
General anesthetics/administration in connection with periodontics, endodontics and other Type III covered services.	50%
Recementing of inlays, crowns, and bridges	50%
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	50%
Repair of crowns, bridgework, and removable dentures	50%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture, or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	50%

Major and Prosthodontic (Type III) Services (12 Month waiting period*)	Plan Pays
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	50%
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old	50%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old	50%

Orthodontia Benefits (Class IV) (12 month waiting period*)	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	50%

***12 month waiting period applies regardless of previous dental coverage, including coverage in the Macon County Basic Dental Plan.**

Summary of Benefits for the Basic Dental Plan Option

Annual Maximum Benefit (per calendar year)	\$1,000 per person
Annual Deductible (per calendar year)	\$50
Orthodontia Maximum Benefit (per lifetime)	N/A

Diagnostic and Preventive Care (Class I) Services (No waiting period)	Plan Pays
Oral exams (limited to 2 per 12 month period)	100%
Bite-wing X-Rays (limited to 1 per 12 month period)	100%

Diagnostic and Preventive Care (Class I) Services (No waiting period)	Plan Pays
Prophylaxis (dental or periodontal) - cleaning of the teeth (limited to 2 per 12 month period)	100%
Topical fluoride application (limited to 1 per 12 month period)	100%

Therapeutic and Restorative (Class II) Services (No waiting period)	Plan Pays
Full mouth x-rays (limited to 1 per 1 in 36 months)	80%
Periapical x-rays (PAS)	80%
Any x-rays needed to diagnose a condition requiring treatment	80%
Topical application of sealants on permanent molars (limit 1 per 36 month period) (limited to children under age 16)	80%
Space maintainers and their fitting (limit 1 per calendar year) (limited to dependent children under age 19)	80%
Emergency palliative treatment to relieve pain	80%
Extraction of teeth, complex oral surgery, and treatment of fractures and dislocations of the jaw (but excluding charges for removal of stitches or post-operative exams)	80%
General anesthetics/administration in connection with oral surgery, fractures, and other Type II covered services.	80%
Injectable antibiotics	80%
Fillings or restorations consisting of amalgam, acrylic, silicate, or composite materials	80%
Consultations with a specialist	80%

Major and Prosthodontic (Class III) Services – NOT COVERED	Plan Pays
Periodontics (treatment of the gums and support structures of the teeth)	0%
Root canals, implants and other endodontic treatments	0%
General anesthetics/administration in connection with periodontics, endodontics and other Type III covered services.	0%
Recementing of inlays, crowns, and bridges	0%
Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for other fillings will be included only when the teeth must be restored with gold.	0%
Repair of crowns, bridgework, and removable dentures	0%
Replacing an existing removable partial or full denture or fixed bridgework, adding teeth to an existing partial denture, or adding teeth to existing bridgework to replace newly extracted natural teeth. Applies only if existing denture or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.	0%
Rebasing of removable dentures or existing dentures which have not been replaced by a new denture	0%
Full to partial dentures, fixed bridges, or adding teeth to an existing denture due to loss of natural teeth while participant is covered under the Plan, or to replace an existing prosthesis which is over five years old	0%
Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five years old	0%
Orthodontia Benefits (Class IV) – NOT COVERED	Plan Pays
Treatment and services necessary to move and correct the position of maloccluded or malpositioned teeth.	0%

Dental Exclusions

The following list includes some common dental charges which are not covered under the Plan:

- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;
- Charges in excess of the maximum amount payable under the Plan (see “Maximum Allowed Amount”);
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse’s parent, child, brother, or sister;
- Correction of congenital conditions;
- Cosmetic services, including personalization or characterization of dentures, bleaching of teeth, facing on pontics or crowns posterior to the second bicuspid, or precision attachments;
- Crowns for teeth that are restorable by other means for the purpose of periodontal splinting;
- Crowns, fillings, or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, restoring the bite (occlusion) or that are cosmetic in nature;
- Drugs or medicines other than antibiotic injections and desensitizing medications administered by your dentist;
- Duplicate prosthetic devices or other dental applications;
- Education and training in personal oral hygiene, dental plaque control, or dietary and nutritional counseling;
- Expenses for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics;
- Expenses for initial placement of a complete or partial denture or fixed bridgework if it involves replacement of one or more natural teeth missing or lost prior to the effective date of coverage;
- Expenses for any dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth);

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- Occlusal analysis, occlusal adjustments, mouth guards or occlusal guards, or any similar take home item;
 - Replacement of a lost, missing, or stolen prosthetic device or other dental appliance;
 - Retreatment or additional treatment necessary to correct or relieve results of a previous treatment;
 - Services of anesthesiologists;
 - Services or supplies which are covered by any employer's liability laws;
 - Services or supplies which are covered by any workers' compensation or occupational disease laws;
 - Services that do not meet the standards of dental practices, accepted by the American Dental Association;
 - Treatment which is considered to be experimental by the dental profession;
 - Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
 - Treatment received before becoming covered under the Plan or after coverage terminates;
 - Veneers (bonding of coverings to the teeth).

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the Claims Administrator at the number listed on the back of your dental ID card.

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the Claims Administrators;
- what to do if a benefit claim is denied; and
- your rights under ERISA and other Federal laws such as COBRA.

Plan Sponsor and Administrator

Macon County is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number.

Macon County
5 West Main Street
Franklin, NC 28734
828-349-2026

As set forth in Section 3(16) under ERISA, the Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan as specifically set forth in ERISA.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility

necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is July 1 through June 30.

Type of Plan

This Plan is called a “welfare plan”, which includes group health plans under ERISA; they help protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 56-6000930 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. Assets of the Plan are used for the exclusive purpose of providing benefits to Plan participants and their beneficiaries. Any premium contributions will remain part of the general assets of the Company and benefits will be paid solely from those general assets.

Claims Administrators

The Plan Administrator has contracted with the following company(ies) to administer benefits and pay claims. You may contact the appropriate Claims Administrator directly, using the information listed below. Your Claims Administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical /Prescription Drugs/COBRA /Utilization Review /Dental

Claims Administrator

Crescent Health Solutions, Inc.
1200 Ridgefield Blvd.

Suite 215
Asheville, NC 28806
828-670-9145
crescenths.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

Macon County
5 West Main Street
Franklin, NC 28734
828-349-2026

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Company elects to pay such expenses.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan

Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative ("Plan Administration Employee") of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: ERISA, COBRA, USERRA, HIPAA, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle's Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims — If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate Claims Administrator. In most cases, the Claims Administrator will reimburse you directly. Occasionally, however, the Claims Administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your Claims Administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

For medical expenses, your Claims Administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate Claims Administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Time Frames for Processing a Claim

Claim Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information	hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.*	Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim	For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*	Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. The time frames for appealing a claim are shown in the following chart.

If you or your representative submits an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did

not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

<i>Time Frames for Appealing Denied Claims</i>				
Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator’s decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights/ Independent Review Organization (“IRO”)

On August 23, 2010, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury collectively released interim guidance to establish procedures for the Federal external review process required by healthcare reform.

Until the final procedure becomes available, the Plan will make every effort to comply with the limited-enforcement safe harbor provisions established by DOL Technical Release 2010-01 which provides guidance on the interim review process for self-funded group health plans.

If your final appeal for a claim is denied, you will be notified in writing that your claim is eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. You must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator, and the Plan.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan; and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
 - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
 - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
 - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
 - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
 - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will be coordinated with Medicare. Which plan pays first ("primary") is determined by whether your Employer is considered a small or large group employer. Generally, for large group employer plans, Medicare requires the employer's plan to pay first and Medicare pays second ("secondary"). You should check with your Employer if you become eligible for Medicare while employed to determine if your Employer's coverage will be primary or secondary.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

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- any deductible under the automobile coverage;
 - any co-payment under the automobile coverage;
 - any expense properly denied by the automobile coverage that is a covered expense; and
 - any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
 - underinsured or uninsured motorist insurance;
 - medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
 - Workers' Compensation coverage; or
 - any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. 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 state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or

obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your Rights under ERISA

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate “Notice of Privacy Provisions” which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan

Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage. The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the “qualifying event.” These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child’s birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).

-
- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
 - The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan's pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan's requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
 - The individual becomes entitled to Medicare.
 - The Company terminates its group health plan coverage for all employees.
 - Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
 - a scheduled vacation;
 - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
 - a scheduled day off within the participant's working schedule; or
 - an absence excused by the Company.

Birth Center

A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

Centers of Excellence

Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas-kidney, and bone marrow transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

Chiropractic Care

Services provided by a Chiropractor (D.C.) or licensed physician (M.D. Or D.O.) including office visits, diagnostic xrays, manipulations, supplies, heat treatment, cold treatment and massages.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Custodial Care

Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment

Equipment such as braces, crutches, hospital beds, etc, that is primarily and customarily used to serve a medical purpose that:

- can stand repeated use;
- generally is not useful to a person in the absence of an illness or injury;
- is appropriate for use in the home.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

A person who works for the Company in an employer-employee relationship.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial actually is subject to FDA oversight; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information

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

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Hospice

A licensed (if required by the state in which it is located) facility set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
 - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
 - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person. :

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- in accordance with standards of good medical practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the eligible diagnosis of the condition;
- not experimental or investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a calendar year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Skilled Nursing Facility

A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended.

Adoption of the Plan

The Macon County Employee Benefit Plan, effective 07/01/2001, as amended and restated herein, is hereby adopted as of 07/01/2014. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 2014.

BY: _____

TITLE: _____

Appendix A

Precertification

The following procedures require precertification:

- Non-emergency inpatient admissions and/or surgeries
- Non-emergency inpatient, partial-day psychiatric services or behavioral health services, including chemical dependency
- Extended Care Facility (any type), Home Health Care, Private Duty Nursing and Hospice
- Non-emergency inpatient rehabilitation admission
- Durable Medical Equipment
- Sleep studies and related expenses
- Chemotherapy and Radiation treatments
- Dialysis
- Outpatient or surgical procedures, including all invasive (puncture or incision of the skin or insertion of instrument or foreign invasion of the body) procedures and non-invasive diagnostic procedures. These could include:
 - Cardiac Catheterization, PTCA
 - CABG or pacemaker implantation
 - Breast or other biopsy, excluding those done in the physician office
 - CT, MRI and PET scans
 - ESWL (lithotripsy)
 - Endoscopy (EGD, ERCP, colonoscopy)
 - Oral or TMJ surgery
- Orthopedic procedures including arthroscopy or carpal tunnel repair
- Outpatient rehabilitation including speech, occupational and physical therapy
- Health Management should be notified of maternity services during the first trimester of pregnancy
- Notification and request for retrospective certification must be made within 48 hours of emergency admission or surgery