PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

CITY OF HANNIBAL AND BOARD OF PUBLIC WORKS
MEDICAL BENEFIT PLAN

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INTRODUCTION

This document is a description of City of Hannibal and Board of Public Works Medical Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

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. 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 health plans.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 72 hours or less for a vaginal delivery or 120 hours or less for a cesarean delivery.

Inpatient Services	
► Elective Admissions ► Emergency Admissions ► Skilled Nursing Facility Admissions ► Rehabilitation Facility Admissions ► LTAC Admissions ► Hospice	► Cervical Spine Surgery ► Lumbar Spine Surgery ► Sacroiliac Joint Fusion ► Transplants ► Computer Navigation for Orthopedic Surgery
Surgical Procedures	
► Blepharoplasty/Blepharoptosis ► Bone-Anchored Hearing Aids ► Breast Procedures ► Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter Defibrillator ► (CRT/ICD) for Treatment of Heart Failure ► Cartilage Transplant Knee ► Cervical Spine Surgery ► Cochlear Implant ► Computer Navigation for Orthopedic Surgery ► Cosmetic and Reconstructive Services of Head, Neck, Trunk and Groin ► Elective Total Hip Arthroplasty ► Elective Total Knee Arthroplasty ► IDET Procedure	► Implantable Cardioverter-Defibrillator (ICD) ► Lumbar Spine Surgery ► Mandibular/Maxillary Surgery (Orthognathic) ► Mastectomy for Gynecomastia ► Nasal Septoplasty ► Panniculectomy and Lipectomy/Diastasis Recti Repair ► Reduction Mammoplasty ► Rhinoplasty ► Sacroiliac Joint Fusion ► Sinus Endoscopy ► Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty ► Treatment of Varicose Veins (Lower Extremities)
Ancillary Services	
► Air Ambulance ► Botulinum Toxin – Review for Migraine Use Only ► Home Health Services ► Genetic Testing for Breast and/or Ovarian Cancer Syndrome ► Genetic Testing for Inherited Peripheral Neuropathies ► Genetic Testing for PTEN Hamartoma Tumor Syndrome	► Home Hospice ► Home Infusion Services ► Hyperbaric Oxygen Therapy (Systemic/Topical) ► Occupational Therapy ► Physical Therapy ► Private Duty Nursing ► Speech Therapy

Diagnostic Imaging - Ambulatory	
► MRA of the Head and/or Neck ► MRI of the Brain ► MRI of Spine – Cervical, Thoracic, Lumbar, Sacral	► PET Scans ► Coronary CT Angiography (CCTA) ► Coronary MRA ► Cardiac MRI
Durable Medical Equipment	
► Tens Unit ► Neuromuscular Stimulators ► Custom Wheelchairs ► Power Wheelchairs ► Cooling Devices (i.e. Polar Care) ► Infusion Pumps ► Insulin Pumps ► Limb Prosthetics	► Wound Vacs ► Electric Scooters ► Bone Stimulator ► Cardio/External Defibrillator ► LVAD – Reviewed by Transplant ► Myoelectric prosthetics ► CPAP/BIPAP
Specialty Infusion Drugs	
► Azacitidine (Vidaza) ► Bevacizumab (Avastin) – Review for non-eye only ► Bortezomib (Velcade) ► Botulinum Toxin - Review for Migraine Use only ► Etanercept (Enbrel) ► Fulvestrant (Faslodex) ► Immune Globulin (Intravenous)	► Infliximab (Remicade) ► Ipilimumab (Yervoy) ► Nivolumab (Opdivo) ► Paclitaxel (Abraxane only) ► Panitumubab (Vectibix) ► Pembrolizumab (Keytruda) ► Pemetrexed (Alimta) ► Rituximab (RituXan) - Review for non-oncology diagnosis/treatment only)

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles payable by Plan Participants

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

2020 MEDICAL BENEFITS SCHEDULE

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Lifetime Maximum	Unlimited		
Calendar Year Deductible			
• Individual	$500	$1,000	$2,000
• Family	$1,000	$2,000	$4,000
Covered expenses for Open Access III Providers and PPO Providers will accumulate to satisfy the Open Access III Providers and PPO Providers deductible amounts simultaneously until the Open Access III Providers and PPO Providers deductible amounts are satisfied. However, only charges made by Non-Network providers will be used to satisfy the Non-Network deductible amounts.			
Calendar Year Out-of-Pocket Maximum (including deductible, coinsurance and medical and prescription drug copays)			
• Individual	$2,500	$3,000	$5,000
• Family	$5,000	$6,000	$7,500
Covered expenses for Open Access III Providers, PPO Providers or Non-Network providers will accumulate to satisfy the Open Access III Providers, PPO Providers or Non-Network Providers out-of-pocket maximums simultaneously until the Open Access III Providers and PPO Providers out-of-pocket maximums are satisfied. However, only charges made by Non-Network providers will be used to satisfy the remainder of the Non-Network out-of-pocket maximum.			
Health Reimbursement Account Services rendered at an Open Access III Provider that are more than 50 miles from Hannibal, MO are eligible for a reimbursement of $250 per occurrence with a maximum of $500 per person/$1,000 per family.			
Utilization Review Requirements Please refer to the HealthLink pre-certification list for full details. It is the Employee's responsibility to obtain pre-certification or benefits will be reduced by a $500 penalty. Penalty does not apply toward the Calendar Year deductible or out-of-pocket maximum.			
Hospital Services • Inpatient **(See Utilization Review Requirements)**	100% after deductible	80% after deductible	50% after deductible
• Outpatient	100% after deductible	80% after deductible	50% after deductible
• Inpatient Services and Outpatient Surgery performed at any facility owned or operated by **Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center**. **DOES NOT APPLY TO EMERGENCY SERVICES, MATERNITY SERVICES OR PHYSICIAN OFFICE VISITS.**	$500 copay per occurrence, then 100% after deductible	80% after deductible	50% after deductible
Diagnostic Services (Lab and X-Ray performed in the physician office)	100% after deductible		
Diagnostic Services (MRI, PET or CT Scans)	100% after deductible	80% after deductible	50% after deductible
MRI, PET or CT Scans performed at Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic, Blessing Physician Services, and Quincy	$500 Copay then 100% after deductible		
Emergency Room Services	100% after deductible	100% after deductible	100% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDER
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Hospital Pre-Admission Testing Within 7 days prior to admission.	100% after deductible	80% after deductible	50% after deductible
Second Surgical Opinion Voluntary	100% no deductible	100% no deductible	100% no deductible
Physician Office Visits	100% after deductible	80% after deductible	50% after deductible
Other Physician Services • Hospital visits • Surgeon and assistant surgeon • Anesthesiologist • Radiologist and pathologist • Emergency room Physician	100% after deductible	80% after deductible	50% after deductible
Note: Services of radiologists, anesthesiologists, pathologists and emergency room Physicians will be reimbursed at the same benefit level as the facility where the services are performed.			
Outpatient X-ray and Laboratory Services	100% after deductible	80% after deductible	50% after deductible
Maternity Female Employee and Spouse.	100% after deductible	80% after deductible	50% after deductible
Well Newborns Well newborn expenses for Hospital, Physician visits and circumcision while mother and baby are confined are paid as part of mother's claim.	100% after deductible	80% after deductible	50% after deductible
Wellness Care			
• Well Child Care, including office visits, routine examinations and laboratory tests as recommended by the American Academy of Pediatrics for up to age 6.	100% no deductible	100% no deductible	50% after deductible
• Immunizations:			
- Birth through 18	100% no deductible	100% no deductible	50% after deductible
• Routine Care – ages 6 and above as follows: - Mammogram – one per Calendar Year unless recommended more frequently by a Physician - Pap smear, including exam – one per Calendar Year - Prostate screening, including exam and any required tests - one per Calendar Year - Colorectal cancer screening and related tests - one per Calendar Year - Flu shot – one per Calendar Year - Screening colonoscopies in accordance with AMA guidelines.	100% no deductible	100% no deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Mental/Nervous Disorders			
- Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician	100% after deductible	80% after deductible	50% after deductible
- Inpatient Services at **Hannibal Regional and Blessing Hospital**	$500 copay per occurrence, then 100% after deductible	N/A	N/A
• Outpatient treatment - Psychotherapy. - Medicine checks, Diagnostic Charges, etc.	100% after deductible	80% after deductible	50% after deductible
Alcoholism and Drug Abuse			
• Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician	100% after deductible	80% after deductible	50% after deductible
- **Inpatient Services at Hannibal Regional and Blessing Hospital**	$500 copay per occurrence, then 100% after deductible	N/A	N/A
- Outpatient treatment	100% after deductible	80% after deductible	50% after deductible
Skilled Nursing Facility Must be within 14 days of a 3-day Hospital or Skilled Nursing Facility confinement, up to a maximum of 70 days per Calendar Year.	100% after deductible	80% after deductible	50% after deductible
Home Health Care Limited to a maximum of 100 visits per Calendar Year. One visit equals 4 hours.	100% after deductible	80% after deductible	50% after deductible
Hospice Care Limited a Lifetime maximum of 70 days, Inpatient or Outpatient.	100% after deductible	80% after deductible	50% after deductible
Physical, Speech & Occupational Therapy Limited to a combined maximum of 90 visits per Calendar Year	100% after deductible	80% after deductible	50% after deductible
Ambulance	100% after deductible		
Durable Medical Equipment	100% after deductible	80% after deductible	50% after deductible
Chiropractic Care Limited to a maximum of 26 visits per Calendar Year, including Diagnostic Charges.	100% after deductible	80% after deductible	50% after deductible
Temporomandibular Joint (TMJ) Syndrome Limited to a maximum of $5,000 per Calendar Year	100% after deductible	80% after deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Organ Transplants	100% after deductible	80% after deductible	50% after deductible
• Donor expenses limited to a maximum of $10,000 per transplant	100% after deductible	80% after deductible	50% after deductible
• Reasonable lodging, meals and transportation expenses for the covered recipient and one other individual, limited to $150 per day and $10,000 per transplant.	100% after deductible	100% after deductible	100% after deductible
All Other Covered Charges	100% after deductible	80% after deductible	50% after deductible
Note: Covered expenses rendered by a Non-Network provider: • for a Covered Person while traveling outside the Network service area; • for a Full-Time Student attending school outside the Network service area; • for a Covered Person residing outside the Network service area; will be reimbursed at the Non-Network level of benefits.			

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS	PRESCRIPTION DRUG PROGRAM PAYS
Drugs available only through the Prescription Drug Program	
Retail (greater of 34-day supply or 100 unit dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Mail Order (greater of 90-day supply or 300 units dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Specialty Medications	100% after 25% Copay and with a $2,500 out-of-pocket maximum Per Calendar Year

Prescription drug coverage for members is administered by EnvisionRx, which is a pharmacy benefits manager. EnvisionRx provides a nationwide network of participating pharmacies and also provides a drug formulary. The EnvisionRx prescription drug formulary is divided into "tiers." The presence of a drug on this formulary does not guarantee coverage. The drugs listed on the EnvisionRx formulary are subject to change. For additional information go to www.envisionrx.com or call 1-833-684-7258.

Coverage for generic and name brand medications above $350 and specialty medications are only applicable if patient advocacy fails to provide a patient assistance program. Patient assistance comes from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. The plan may cover the cost of patient assistance options so that your out of pocket cost will not exceed the cost under the pharmacy benefit. The plan may also allow for a 60-day grace period for urgent medications to allow time to complete the patient assistance process. Prior authorization is required on all specialty medications.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 1500 hours per calendar year and is on the regular payroll of the Employer for that work.

(2) is in a class eligible for coverage.

(3) completes the employment Waiting Period which begins on the date of employment and ends on the first day of the month following the date of employment ends as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Eligibility Requirements for Retired Employee Coverage. A person is eligible for Retired Employee coverage provided that he:

(1) is a Retired Employee under age 65, who retires under the formal written Retirement Plan of the Covered Employer;

(2) is covered as an Active Employee on the day prior to his retirement; and

(3) elects to contribute to the Plan the required contribution for Retired Employee coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, foster child, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The term "children" shall include natural or adopted children, who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

When a Qualified Dependent reaches the applicable limiting age, coverage will end at the end of the Calendar Year.

If a covered Employee or Spouse is the Legal Guardian of a child or children, under the limiting age of and primarily dependent upon the Employee for support and maintenance, these children may be enrolled in this Plan as Qualified Dependents.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(3) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Employer shall determine the portion of the cost of coverage to be paid by participants for Dependent coverage. This information will be communicated to Employees from time to time.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins immediately after enrollment.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, City of Hannibal and Board of Public Works, 320 Broadway, Hannibal, Missouri, 63041, 573-221-8050 or 572-221-0111.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to

individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan on the date that the Eligibility Requirement is met:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

Eligible Dependents of Retired Employees. Dependents of Retired Employees are subject to the same rules shown under the Dependent Coverage provision, and are eligible provided:

(1) they were a covered Dependent of the Active Employee on the day prior to his retirement (unless the Retired Employee experiences a change in family status as described in the Special Enrollments provisions); and

(2) the Retired Employee makes the required contributions.

TERMINATION OF COVERAGE

For Plan Years that begin before January 1, 2014, Plan Participants who lose coverage under the Plan will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date on which all vacation and/or sick pay has been paid.

For leave of absence or layoff only: the date on which all vacation and/or sick pay has been paid.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring/Reinstatement of a Terminated Employee.

An Employee who has a break in service with no hours worked, who was enrolled on the plan at the time the break in service commenced, and who resumes working within 13 weeks of the commencement of the break in service, will be eligible to reinstate the level of coverage that was in place prior to the break in service, immediately upon returning to work, assuming all other eligibility criteria are satisfied.

If an Employee has a break in service with no hours worked that is in excess of 13 weeks, the new hire waiting period and all other eligibility criteria apply.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator City of Hannibal and Board of Public Works, 320 Broadway, Hannibal, Missouri, 63041, 573-221-8050 or 572-221-0111. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Retired Employee Coverage Terminates

(1) the date the Plan is terminated;

(2) attainment of age 65, or the date of Medicare entitlement due to disability, whichever occurs first;

(3) the end of the month the person fails to make the required contribution.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) On the last day of the Calendar Year in which a Dependent child reaches the limiting age as defined by the Plan.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

(7) the end of the month the Retired Employee’s Dependent attains age 65.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every May 1 through May 31st, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage's are right for them.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage's.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. A deductible is the amount of covered expenses the Employee and Dependent(s) must incur during each year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any family member during the remainder of that year. The family Calendar Year deductible can be accumulated through any combination of family members. The individual and family Calendar Year deductibles are shown in the Schedule of Medical Benefits.

Covered expenses for Open Access III Providers and PPO Providers will accumulate to satisfy the Open Access III Providers and PPO Providers deductible amounts simultaneously until the Open Access III Providers and PPO Providers deductible amounts are satisfied. However, only charges made by Non-Network providers will be used to satisfy the Non-Network deductible amounts.

Deductible Three Month Carryover. Any eligible charges during October, November and December which are used to satisfy all or part of the Calendar Year deductible for that year can be carried over into the next year and applied toward that year's Calendar Year deductible. Both the individual and the family Calendar Year deductibles will carry over to the next year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

The Plan also limits the Covered Person's share of covered expenses for all family members combined, during a single Calendar Year. Once the limit is reached, the Plan will pay most covered expenses at 100% for all family members for the remainder of that Calendar Year.

The individual and family out-of-pocket maximums are shown in the Schedule of Medical Benefits.

Covered expenses for Open Access III Providers, PPO Providers or Non-Network providers will accumulate to satisfy the Open Access III Providers, PPO Providers or Non-Network Providers out-of-pocket maximums simultaneously until the Open Access III Providers and PPO Providers out-of-pocket maximums are satisfied. However, only charges made by Non-Network providers will be used to satisfy the remainder of the Non-Network out-of-pocket maximum.

Some Expenses Do Not Apply Toward the Out-of-Pocket Maximum. Not all expenses may be used to accumulate toward the out-of-pocket maximum, nor will these charges be payable at 100% in the event the out-of-pocket maximum has been met:

(1) Non-Network expenses that exceed Usual, Customary and Reasonable Charges.

(2) Network expenses that exceed the negotiated fee.

(3) Expenses that are not covered by the Plan.

(4) Penalties for failure to comply with Pre-Certification/Utilization Review Requirements.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the City of Hannibal and Board of Public Works Medical Benefit Plan, including the ones described in this document. The Maximum Benefit Amount for Essential Health Benefits will not apply in Plan Years beginning on or after January 1, 2014.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** Eligible Hospital expenses include:

(a) semi-private room;

(b) private room - the Plan allows the Hospital's average semi-private room rate except when deemed Medically Necessary by the Physician or in “private-room-only” Hospitals in which case the Plan will allow the most common private room rate;

(c) Intensive Care Unit room and board when Medically Necessary;

(d) Inpatient miscellaneous charges;

(e) Outpatient Hospital expenses.

Hospital confinement expenses for dental services if the attending Physician certifies that hospitalization is necessary to safeguard the health of the patient.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 120 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 72 hours (or 120 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 72 hours (or 120 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the confinement starts within 14 days of a Hospital confinement of at least 3 days; and

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services. Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature.

(6) **Home Health Care Services and Supplies.** On occasion, Home Health Care may be needed instead of care from a full-service Hospital. The Plan covers Home Health Care visits up to the maximum shown in the Schedule of Medical Benefits. A Home Health Care visit is comprised of up to four hours of home health aide care or each visit by any other member of a Home Health Care team. In order to qualify for Home Health Care, the patient must be under the care of a Physician who submits a "Home Health Care plan" (a written program for care and Treatment in the patient's home and certification that Inpatient confinement in a Hospital or Skilled Nursing Facility would be required if the home care were not provided).

Covered expenses include, but are not limited to, charges from a Home Health Care Agency for the following:

(a) part-time nursing care by or under the supervision of a Nurse;

(b) part-time home health aide services;

(c) physical, occupational, respiratory, and speech therapy;

(d) medical supplies, laboratory charges, etc., Medically Necessary for Treatment.

Eligible Home Health Care services will not include:

(a) Custodial Care, meals, or nutritional services;

(b) housekeeping services;

(c) transportation services;

(d) care for Alcoholism or Drug Abuse;

(e) care for the deaf or blind;

(f) care for senility or mental deficiency or retardation, or Mental/Nervous Disorder.

(7) **Hospice Care Services and Supplies.** When an attending Physician recommends a plan of Hospice Care for an individual who is terminally ill (where life expectancy is less than 6 months), expenses for such Hospice Care provided through a Hospice Agency under a Hospice Care plan will be payable up to the maximum benefit shown in the Schedule of Medical Benefits.

Covered expenses include, but are not limited to, charges from a Hospice Agency for the following:

(a) nursing services;

(b) physician's services;

(c) home health aide and homemaker services;

(d) medical social services;

(e) medical supplies and appliances;

(f) inpatient care;

(g) counseling.

Hospice Care coverage does not pay for:

(a) services provided by persons who do not regularly charge for their services;

(b) treatment intended to cure the terminal Illness;

(c) funeral services.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) **Allergy** testing.

(b) Local Medically Necessary professional land or air **ambulance** service. 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.

(c) **Ambulatory** (Outpatient) Surgical Facility.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Birthing** Center.

(f) **Blood** and/or plasma, if not donated or replaced, intravenous injections and solutions, and the equipment for the administration.

(g) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(h) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(i) **Circumcision.**

(j) Initial **contact lenses** or glasses required following cataract surgery.

(k) **Contraceptive** injectables (i.e., Depo Provera) and devices (i.e., IUD, diaphragm and NuvaRing) as well as the fitting thereof for covered Employees or Spouses.

(l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(m) **Hospital pre-admission** testing performed on an Outpatient basis provided the tests are:

(i) made within 7 days prior to the date that Inpatient care begins;

(ii) made in the same Hospital where the Inpatient care is scheduled;

(iii) performed in place of tests during Inpatient confinement;

(iv) related to the condition which causes the Inpatient confinement; and

(v) ordered by the same Physician who ordered the Inpatient care.

(n) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(o) **Medical treatment** (e.g., psychiatric care, medication adjustment/management, etc.) in connection with learning disabilities and attention deficit disorders (ADD/ADHD) will be covered.

(p) Treatment of **Mental Disorders and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment limits shown in the Schedule of Benefits. Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(q) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(r) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefits are limited as shown in the Schedule of Benefits.

(s) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to the Organ and/or Tissue Transplant Addendum at the end of the Covered Charges Section.

(t) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Benefits are limited as shown in the Schedule of Benefits.

(u) Termination of **Pregnancy** (abortion) only when the attending Physician certifies that the life of the mother would be endangered if the fetus were carried to term.

(v) **Prescription** Drugs (as defined).

(w) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating

from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - -Women's contraceptives, sterilization procedures, and counseling.
  - -Breastfeeding support, supplies, and counseling.
  - -Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - -Diphtheria,
  - -Pertussis,
  - -Tetanus,
  - -Polio,
  - -Measles,
  - -Mumps,
  - -Rubella,
  - -Hemophilus influenza b (Hib),
  - -Hepatitis B,
  - -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(x) **Prosthetic Devices** and supplies, including their initial purchase, fitting, necessary adjustments, and repairs, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or

malfunctioning body organ or limb, including colostomy bags. Replacement of a Prosthetic Device will be covered, if required due to a change in the patient's physical condition; or, if replacement is less expensive than repair of existing device.

(y) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(z) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Benefits are limited as shown in the Schedule of Benefits.

(aa) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. The Plan will not cover any expenses incurred for preventative or maintenance treatment.

(bb) **Sterilization** procedures.

(cc) Two pair of **support stocking** (e.g. Jobst stockings) per calendar year.

(dd) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(ee) **Voluntary** Second Surgical Opinion**.**

(ff) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 72

hours following a vaginal delivery, or less than 120 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 72 hours (or 120 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 72 hours (or 120 hours).

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(gg) Diagnostic **x-rays**.

(hh) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ),** will be payable up to the maximum benefit shown in the Schedule of Medical Benefits.

ORGAN AND/OR TISSUE TRANSPLANTS ADDENDUM

Pre-Authorization Requirement for Organ Transplant *

Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. (Cornea transplants are not subject to the pre-authorization provision, but will be considered on the same basis as any other medical expense coverage under this Plan.) Transplant coverage is offered under this Plan through a preferred provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten (10) days* after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his physician should contact the Plan Administrator for referral to the network's medical review specialist, for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (One or both confirming second opinions may be waived by the plan's medical review specialist). Additional attending Physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

***** Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other Plan deductible and co-payment requirements that would normally be applicable to the transplant procedure.

Organ Transplant Network

As a result of the pre-authorization review the Covered Person will be asked to consider obtaining transplant services from a participating Center of Excellence facility arranged by the plan administrator. The purpose of designating Centers of Excellence networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of network, but the Covered Person has received approval for the plan's medical review specialist for out of network services, then network benefits will apply to the transplant and it related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

Covered Transplant Expenses

The term "covered expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

(1) Charges incurred in the evaluation, screening, and candidacy determination process.

(2) Charges incurred for organ transplantation.

(3) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

(4) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.

(5) Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

(6) If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the donor's marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period.)

(7) Charges incurred for follow up care, including immuno-suppressant therapy.

(8) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

Re-transplantation

Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-Authorization Requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the plan's overall per-person maximum lifetime benefit.

Accumulation of Expenses

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the plan's overall per-person maximum lifetime benefit.

Donor Expenses

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Extended Benefits in the Event of Termination

In the event of termination of the plan, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are incurred during the lesser of a) the remainder of that transplant benefit period or b) one month after termination of the plan or membership, as though coverage had not ended.

NOTE: THIS ORGAN AND/OR TISSUE TRANSPLANTS ADDENDUM SUPERCEDES ANY SPECIFIC PROVISIONS AND BENEFITS LISTED IN THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION.

HOWEVER. INDIVIDUALS WHO HAVE BEEN EVALUATED FOR A TRANSPLANT PRIOR TO THE EFFECTIVE DATE OF THIS ADDENDUM MAY OR MAY NOT QUALIFY FOR THE HCCB ORGAN TRANSPLANT SOLUTIONS PROGRAM. IF AN INDIVIDUAL HAS BEEN EVALUATED FOR A TRANSPLANT PRIOR TO THE EFFECTIVE DATE OF THIS ADDENDUM AND (FOR THAT REASON) IT IS DETERMINED THAT THE INDIVIDUAL DOES NOT SATISFY CRITERIA FOR THE HCCB TRANSPLANT SOLUTIONS PROGRAM, NORMAL PLAN BENEFITS FOR TRANSPLANTS WILL APPLY.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

Preferred Provider Organization (PPO) Information

HealthLink Open Access III Through Tri-State Coalition Information

The Employer has contracted with HealthLink Open Access III through Tri-State Coalition to arrange for the provision of medical care to Covered Persons at lower costs. HealthLink Open Access III through Tri-State Coalition includes both Open Access III ~~HMO~~ and PPO ~~Network~~ Providers and their qualifications have been reviewed so that Covered Persons will be provided quality care at contracted rates, which are generally less than those that would otherwise be charged by the providers. Covered Persons do not have to elect a primary care Physician, and referrals are not required. The Plan offers Covered Persons the option of using Open Access III ~~HMO~~ ~~Network~~ Providers, PPO ~~Network~~ Providers or Non-Network Providers. The Plan offers Covered Persons the freedom to choose their own providers while encouraging them to utilize the services of Network Providers for their health care needs whenever possible to increase Plan benefits and help control the Plan's overall costs.

A list of Open Access III ~~HMO~~ and PPO ~~Network~~ Providers is available at no cost from the Employer or online at www.healthlink.com. The web site has the most current information and a Covered Person has the option of viewing all participating providers or just looking up a specific Physician.

The benefit level is determined by the provider who is used. When Covered Persons obtain health care services from an Open Access III ~~HMO~~ ~~Network~~ Provider, the Plan will pay benefits as shown in the Open Access III ~~HMO~~ Provider column of the Schedule of Medical Benefits.

Health care services received from a PPO ~~Network~~ Provider will be paid as indicated in the PPO Provider column of the Schedule of Medical Benefits. The Plan has agreed to accept the negotiated rate from PPO providers. When the negotiated rate is higher than the amount billed, the Plan will pay the difference at 100%. However, Eligible Expenses Incurred for services rendered by Network Providers who are in both the Open Access III ~~HMO~~ Network and the PPO Network will be paid at the higher Open Access III Network benefit.

Covered services received from Providers who are outside the Network (Non-Network Providers) will be reimbursed at the lower Non-Network benefit shown in the Schedule of Medical Benefits.

All Plan provisions and exceptions apply to Network Providers and Non-Network Providers.

When services are obtained from a Network Provider, the Provider will submit the expenses on the patient's behalf. Payment for such services will be sent directly to the Network Provider.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity of the services shown on the **SCHEDULE OF BENEFITS** section at the beginning of this Summary of Plan Description before services are provided.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 72 hours or less for a vaginal delivery or 120 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $500.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as shown on the Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as shown on the Schedule of Benefits.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory (Outpatient) Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Amendment is a formal document signed by the representative of the City of Hannibal and the Board of Public Works. The Amendment changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Employer means the City of Hannibal and Board of Public Works.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Diagnostic Charges is the Usual, Customary and Reasonable Charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means any person who is deemed to be that of a common law employee by the Employer (without regard to any classification by any other person or entity, including but not limited to the Internal Revenue Service, a court of competent jurisdiction, an arbitrator, or any federal, state or local government or agency or subdivision thereof) and who is regularly scheduled to work at least 20 hours or more per week. The term "Employee" does not include any "leased employees", independent contractor or any employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

Employer is City of Hannibal and Board of Public Works.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility

studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Lab*One* is the lab card program that allows Covered Persons to obtain free, covered Outpatient laboratory testing when their specimens are sent to Lab*One* for testing. The lab card benefit applies to most diagnostic Outpatient testing covered by the Plan, provided the tests have been ordered by the Covered Person's Physician and are sent to Lab*One* for processing. The lab card program does not cover:

(1) lab work ordered during a Hospital confinement;

(2) lab work needed on an emergency (STAT) basis and time-sensitive, esoteric Outpatient laboratory testing such as, but not limited to, bone marrow studies and spinal fluid tests;

(3) non-laboratory work such as mammography, x-rays, imaging and dental work;

(4) lab work performed by another lab.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maintenance Care means any services and supplies primarily to maintain a level of physical or mental function.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network Provider is a provider who, by a contract with HealthLink Open Access III through Tri-State Coalition (HMO and PPO), agrees to accept the allowable (negotiated/contracted) charge as full payment of covered services, except for deductibles and/or copays. Any deductibles and/or copays are the responsibility of the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Provider is a provider who does not have a contract with HealthLink Open Access III through Tri-State Coalition (HMO and PPO) and may charge more than the Usual, Customary and Reasonable Charge. Any amount in excess of the Usual, Customary and Reasonable Charge is the responsibility of the Covered Person.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means City of Hannibal and Board of Public Works Medical Benefit Plan, which is a benefits plan for certain Employees of City of Hannibal and Board of Public Works and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Residential Treatment Center / Facility means a Provider licensed and operated as required by law, which includes:

(1) Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability;
(2) A staff with one or more Doctors available at all times.
(3) Residential treatment takes place in a structured facility-based setting.
(4) The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
(5) Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
(6) Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for:

(1) Nursing care
(2) Rest care
(3) Convalescent care
(4) Care of the aged
(5) Custodial Care
(6) Educational care

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse is the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes temporomandibular joint dysfunction, arthritis or arthrosis, other craniomandibular joint disorders, and myofacial or orofacial pain syndrome. It does not include a fracture or dislocation which results from an injury, any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint).

Total Disability (Totally Disabled) means:

(1) An Employee who is in a physical state resulting from an illness or injury which wholly prevents them from engaging in his regular or customary occupation and from perform in any and all work for compensation or profit.

(2) In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Utilization Review is a review and determination as to the appropriateness and Medical Necessity of services and supplies.

Waiting Period means the period of time that must pass under this Plan (or for purposes of determining Creditable Coverage, under any other health plan) before an Employee or Dependent is eligible to enroll in the Plan (or other health plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Late Enrollee or Special Enrollee on the special enrollment date, any period before such late or special enrollment is not a Waiting Period.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) **Acupuncture.**

(3) **Adoption expenses.**

(4) **Alternative Medicine**, including but not limited to, biofeedback, hydrotherapy, aromatherapy, naturopathy, and homeopathic and holistic Treatment.

(5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(6) **Cosmetic Surgery**, except as specified in Covered Medical Expenses.

(7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(8) **Dental Services.** Services and supplies for dental services, treatment of teeth or periodontium or occlusive re-alignment of the mandible or maxilla or oral surgery, except as specified in Covered Medical Expenses. Benefits will not be considered for Treatment related to the preparation or fitting of dentures, including dental implants.

(9) **Diabetic Supplies.**

(10) **Educational or vocational testing.** Services for educational or vocational testing or training.

(11) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(12) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(13) **Expenses** for preparing medical reports, itemized bills, or benefit request forms.

(14) **Expenses** for broken appointments or telephone calls.

(15) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(16) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(17) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(18) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(19) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(20) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(22) **Hypnosis.**

(23) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean 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 result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(25) **Mailing** and/or shipping and handling expenses.

(26) **Marital, pre-marital or sex counseling.** Care and treatment for marital, pre-marital or sex counseling.

(27) **Massage** Therapist.

(28) **Medical Equipment.** Purchase or rental of luxury medical equipment when standard equipment is appropriate for the Covered Person’s condition (i.e., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).

(29) **Modifications.** Modifications to the home or property of a Covered Person, such as, but not limited to, escalators, elevators, saunas, steambaths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps.

(30) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(31) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(32) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(33) **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.

(34) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(35) **Non-medical.** Services or supplies provided by non-medical practitioners such as, but not limited to, Christian Science Practitioners and Faith Healers.

(36) **Non-prescription** drugs or medicines.

(37) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(38) **Nutritional counseling** except for the initial consultation which is Medically Necessary because of a medical condition such as diabetes or heart disease.

(39) **Nutritional Supplements.** Vitamins, nutritional supplements or nutritional therapy except when such Treatment is Medically Necessary to sustain life and coverage is not provided under the Prescription Drug Program.

(40) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered.

(41) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(42) **Personal comfort items.** Equipment or other personal comfort items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heating pads, hot water bottles, water beds, allergy-free pillows, blanket or mattress pad covers, orthopedic mattresses, exercising equipment, vaporizers, vibratory equipment, heat lamps, electrolysis, vacuum devices, blood pressure instruments, stethoscopes, thermometers, scales, elastic bandages or stockings, first aid supplies, non-hospital adjustable beds, and any other clothing or equipment which could be used in the absence of an Illness or Injury.

(43) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(44) **Prescription Drugs.** Prescription drugs or medicines. Prescription Drugs are **only** covered under the Prescription Drug Program. Refer to Section VI for a brief overview of the Prescription Drug Program.

(45) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(46) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.

(47) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(48) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(49) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(50) **Specialty Injectable.** Any specialty injectable Prescription Drugs that are covered under the specialty pharmacy segment of the Prescription Drug Program. Specialty injectable drugs obtained and dispensed in the Physician's office will be covered one time but subsequent doses must be obtained through CuraScript.

(51) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(52) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge.

(53) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. MedTrak is the administrator of the pharmacy drug plan.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Prescription Drugs purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used are not covered.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, MedTrak, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Prescribed medications that are covered by the prescription drug plan are also covered by the mail service prescription drug plan if they are normally available at a local Pharmacy. However, certain medications cannot be supplied easily by mail (for example, drugs requiring constant refrigeration). Verify with the Prescription Drug Program that the medication is available through the mail service.

Specialty Medication Program. A Step Therapy Program and Specialty Medication Program has been added see Description of Prescription Drug Benefits.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

(5) Oral contraceptives prescribed for birth control for a covered Employee or Spouse.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Allergy extracts.**

(3) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(5) **Contraceptive** injectables (i.e., Depo-Provera) and devices (i.e., IUD, diaphragm).

(6) **Cosmetics.** Drugs for cosmetic uses.

(7) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(8) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(9) **FDA.** Any drug not approved by the Food and Drug Administration.

(10) **Immunization.** Immunization agents or biological sera.

(11) **Impotence.** A charge for impotence medication.

(12) **Infertility.** A charge for infertility medication.

(13) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(14) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(15) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(16) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(18) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(19) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(20) **Smoking cessation.** Products and drugs for smoking cessation or deterrence.

Refer to the Managed Prescription Drug Program Agreement for a complete list of covered and non-covered Prescription Drugs. For any questions regarding the prescription drug plan or the mail service prescription drug plan, contact the Prescription Drug Program.

HOW TO SUBMIT A CLAIM

Submit all expenses to the address appearing on the Employee identification card. The ID card should be shown to providers each time services are received. If the provider submits the charge directly to the address on the ID card, it will aid in correct claims submission and timely claims processing.

A claim is considered to be filed when the Claim Administrator receives a billing which includes the following information:

(a) the Employee's name and identification number;

(b) the patient's name;

(c) a description of services or supplies provided, detailing the charge for each supply or service;

(d) the diagnosis;

(e) the date(s) of service;

(f) the provider's name and degree, address, telephone number, and tax identification number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. Additional information must also be provided to the Claim Administrator, although providing this information is not a requirement for the claim to be deemed to be filed. This additional information includes, but is not limited to:

(a) accident date and details;

(b) verification of Dependent eligibility;

(c) full-time student verification;

(d) coordination of benefit information, i.e., if another plan is the primary payer, a copy of their explanation of benefits (EOB);

(e) subrogation agreement.

Any initial claim payment or subsequent claim payment from an adjustment (e.g., PPO Network pricing, Medicare, payment error, etc.) will be considered part of the original claim.

Always retain a copy of the bill(s) for your records.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within one year of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days..

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under applicable law following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. In addition, a statement that "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office."

Voluntary appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This information is included as part of the Plan Document/Summary Plan Description. For additional information about your rights and obligations under the Plan and under the federal law, you should contact the Plan Administrator.

What Is COBRA Continuation Coverage?
COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". You, your Spouse and your Dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (the full cost means the Employee and Employer cost of coverage) before the group health coverage is continued **and** monthly payments must be made in order to continue the coverage.

If you are an Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

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

If you are the Spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happens:

- Your Spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment end for any reason other than gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (Part A, Part B or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The Child stops being eligible for coverage under the Plan as a "Dependent Child".

When Is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or the reduction of hours of employment, death of Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee becoming entitled to Medicare benefits (Part A, Part B or both), the Employer must notify the Plan Administrator within thirty (30) days of any of these events.

You Must Give Notice Of Some Qualifying Events
For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within sixty (60) days after the Qualifying Event occurs. Your written notice should include the date of the Qualifying Event. If you or your Spouse are notifying the Plan Administrator of a divorce or legal separation, you or your Spouse should provide a copy of the legal separation papers or divorce decree. You must provide this notice to: City of Hannibal and Board of Public Works.

If you fail to give written notice with the sixty (60) day time period, the Spouse and/or Dependent Child shall lose the right to elect COBRA continuation coverage.

How Is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Employee, your divorce or legal separation, a Dependent Child's losing eligibility as a Dependent or loss of coverage due to Medicare Entitlement (under Part A, Part B or both), COBRA continuation lasts for up to a total of thirty-six (36) months.

When the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than eighteen (18) months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the Employee lasts until thirty-six (36) months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Children can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the Qualifying Event (thirty-six (36) months minus eight (8) months).

Otherwise, when the Qualifying Event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability Extension Of The Eighteen (18) Month Period
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be Disabled and you notify the Plan Administrator in writing in a timely fashion, you and your entire family may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The disability would have to have started some time before the sixtieth (60th) day of COBRA continuation coverage and last at least until the end of the eighteen (18) month period of COBRA continuation coverage. A copy of the Notice of Award from the Social Security Administration **must** be submitted to the Plan Administrator and the COBRA Administrator within sixty (60) days of receipt of Notice of Award and before the end of the eighteen (18) month period of COBRA continuation coverage.

Second Qualifying Event Extension Of Eighteen (18) Month Period
If your COBRA covered family members experience another COBRA Qualifying Event within the first eighteen (18) months of COBRA continuation coverage, the Spouse and Dependent Children in your family may be eligible to receive up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the secondary event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving COBRA continuation coverage if the Employee or former Employee dies, or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child. In all cases, the eighteen (18) month extension is available only if the second Qualifying Event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

The following example shows how the second Qualifying Event rule works. Former Employee A elects eighteen (18) months of COBRA continuation coverage for the entire family. After the first six (6) months of COBRA continuation coverage, former Employee A becomes entitled to Medicare (Part A, Part B or both). If former Employee A were still actively employed, entitlement to Medicare **would not** result in a loss of coverage under the Employer's Group Health Plan. The additional eighteen (18) month extension is not available for the former Employee's Spouse and Dependents because if Medicare entitlement had occurred during active employment there would have been no loss of Employer Group Health Plan coverage.

In all of these cases, you must notify the Plan Administrator within sixty (60) days of the second Qualifying Event.

Early Termination Of COBRA Continuation Coverage

COBRA continuation coverage will terminate before the end of the maximum period if:

- The Qualified Beneficiary fails to make the required contributions when due;
- The Qualified Beneficiary becomes covered under another Group Health Plan after the date of the COBRA election;
- The Qualified Beneficiary becomes entitled to Medicare benefits (Part A, Part B or both) after electing COBRA continuation coverage; or
- The Employer ceases to provide any Group Health Plan for its Employees.

How Can You Elect COBRA Continuation Coverage?
To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each Qualified Beneficiary has a separate right to elect COBRA continuation coverage. For example, the Employee's Spouse may elect COBRA continuation coverage even if the Employee does not. COBRA continuation coverage may be elected for only one, several or for all Dependent Children who are Qualified Beneficiaries. A parent may elect to continue COBRA continuation coverage on behalf of any Dependent Children. The Employee or the Employee's Spouse can elect COBRA continuation coverage on behalf of all of the Qualified Beneficiaries.

You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the Qualifying Event listed above. You will also have the same special enrollment right at the end of COBRA continuation coverage if you elect COBRA continuation coverage for the maximum time available to you.

How Much Does COBRA Continuation Coverage COST?
Generally, each Qualified Beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA continuation coverage due to a disability, one hundred fifty percent (150%) of the cost to the Group Health Plan (including both employer and Employee contributions) for coverage of a similarly situated plan Participant or Beneficiary who is not receiving COBRA continuation coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost sharing requirements are for other health coverage options. For example,

one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

When and How Must Payment for COBRA Continuation Coverage be Made?

First Payment For COBRA Continuation Coverage
If you elect COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA continuation coverage not later than forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator or Plan Administrator to confirm the correct amount of your first payment.

Periodic Payments For COBRA Continuation Coverage
After you make your first payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each Qualified Beneficiary is shown on the Election Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for COBRA continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace Periods For Periodic Payments
Although periodic payments are due on the dates shown above, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to the Plan Administrator or COBRA Administrator.

If You Have Questions
Questions concerning your Plan or your COBRA continuation rights should be addressed to the contact identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting Group Health Plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa

Keep Your Plan Informed
In order to protect your family's rights, you should keep the Plan Administrator informed of any change in marital status, Dependent status or address change. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

City of Hannibal and Board of Public Works
320 Broadway
Hannibal, Missouri 63041

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. City of Hannibal and Board of Public Works Medical Benefit Plan is the benefit plan of City of Hannibal and Board of Public Works, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by City of Hannibal and Board of Public Works to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, City of Hannibal and Board of Public Works shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of City of Hannibal and Board of Public Work's workforce are designated as authorized to receive Protected Health Information from City of Hannibal and Board of Public Works Medical Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan:

(1) City Clerk, City of Hannibal

(2) Assistant City Clerk, City of Hannibal

(3) Personnel Clerk, Board of Public Works

(4) Chairman, Hannibal Employee Benefit Trust Board

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage, but only for Plan Years that begin before January 1, 2014.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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 a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

IMPORTANT NOTICES

Mental Health Parity and Addiction Equality Act

This Plan will comply with the Mental Health Parity and Addition Equity Act and ERISA Section 712. The Plan does not have any restrictions on mental health benefits that are greater than the restrictions on medical care benefits.

Genetic Information Nondiscrimination Act of 2008

This Plan will not deny coverage to a healthy individual or charge that person higher premiums based solely on a genetic predisposition to developing a disease in the future.

Women's Health and Cancer Rights Act of 1998

Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy.
If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Health Benefits Plan complies with the Women's Health and Cancer Rights Act of 1998, which provides for:

— Reconstruction of the breast(s) that underwent a covered mastectomy.
— Surgery and reconstruction of the other breast to restore a symmetrical appearance.
— Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
— All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

Notice of Privacy Practices

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple… we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury

For treatment activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about

treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

— Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.

— Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

— Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.

— Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only

those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: City of Hannibal and Board of Public Works

State Notice of Privacy Practices

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.
We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.
We may share PI with persons or entities outside of our company without your OK in some cases.
If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.
You have the right to access and correct your PI.
Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.
Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Tax Credit Under Trade Act of 2002

If you are eligible, under the Trade Act of 2002, to tax credits for employee contributions paid for health benefit coverage, contact the Internal Revenue Service for instructions.

Notice of Open Enrollment to Add Children Up to Age 26

The Patient Protection and Affordable Care Act (“PPACA”) provides that a child of an employee who is covered by our group medical benefit plan may be covered under the plan until the child turns age 26. If the employee already has coverage that includes children, no additional contribution will be charged. If the employee does not have coverage that includes children, the employee’s coverage will change to include children and the standard employee contribution for that coverage will be applied.

The child does not have to be a financial “dependent” of the employee, but only be the son, daughter, step-son, step-daughter, child legally placed for adoption, adopted child, or a foster child. Also, the child does not have to live in the home of the employee. The child can be married but the coverage will not include the spouse of the child or a child of the child.

A child whose coverage has ended, or who was denied coverage due to not meeting the dependent eligibility rules of the plan may now be added to the plan. A child on COBRA under our plan may now be added back to the employee’s coverage. If our employee is not covered by our plan, the employee must enroll in the plan in order for the child to enroll. The child and employee may enroll in, or switch to, any coverage that we currently offer.

A child is not eligible for coverage under this provision if he is eligible for other group sponsored health coverage through his own employment or through his spouse. A separate form must be filled out to allow us to verify if the child is eligible for other coverage prior to the beginning of coverage. Coverage will not begin for the child until this information is verified. This limitation terminates as of the 2014 renewal date of the benefit plan.

A qualifying child may enroll in the plan effective 07/01/11. The employee has a period of 30 days prior to the effective date, or 30 days from the date of this Notice if coverage is being allowed back to a previous date, in which to enroll the child. Enrollment and other coverage verification forms may be obtained from the Personnel Department.

Compliance with HIPAA Privacy Standards

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) General. The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) Permitted Uses and Disclosures. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) Authorized Employees. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) Updates Required. The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) Use and Disclosure Restricted. An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) Resolution of Issues of Noncompliance. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

Compliance With HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

City of Hannibal and Board of Public Works Medical Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 43-6001552

PLAN EFFECTIVE DATE: January 1

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

City of Hannibal and Board of Public Works
320 Broadway
Hannibal, Missouri 63041
573-221-8050 or 572-221-0111

PLAN ADMINISTRATOR

City of Hannibal and Board of Public Works
320 Broadway
Hannibal, Missouri 63041
573-221-8050 or 572-221-0111

NAMED FIDUCIARY

City of Hannibal and Board of Public Works
320 Broadway
Hannibal, Missouri 63041

AGENT FOR SERVICE OF LEGAL PROCESS

City of Hannibal and Board of Public Works
320 Broadway
Hannibal, Missouri 63041

CLAIMS ADMINISTRATOR

RightCHOICE Benefit Administrators
1831 Chestnut Street
St. Louis, MO 63103
1-800-365-9036