PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR PORT HEALTH SERVICES GROUP HEALTH PLAN

EFFECTIVE: NOVEMBER 1, 2021

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ARTICLE I
INTRODUCTION

This document is a description of Port Health Services Group Health 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 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, Copayments, exclusions, limitations, definitions, eligibility, and the like.

To the extent that an item or service is a Covered Charge under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Network Provider.

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.

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.

The Plan is obligated to pay Clean Claims only.

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.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in the Claims Procedures section within the applicable time deadlines, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

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

This Plan is an employee welfare benefit plan within the meaning of ERISA. This Plan is a self-funded medical plan intended to meet the requirements of Sections 105(b), 105(h) and 106 of the Code so that the portion of the cost of coverage paid by the Employer, and any benefits received by a Plan Participant through this Plan, are not taxable income to the Plan Participant. The specific tax treatment of any Plan Participant will depend on the individual's personal circumstances; the Plan does not guarantee any particular tax treatment. Plan Participants are solely responsible for any and all federal, state, and local taxes attributable to their participation in this Plan, and the Plan expressly disclaims any liability for such taxes. This Plan is “self-funded,” which means benefits are paid from the Employer's general assets or a trust and are not guaranteed by an insurance company.

The Plan is administered by the Plan Administrator, which is the primary named fiduciary of the Plan, within the purview of ERISA and in accordance with these provisions. The Plan Administrator may delegate certain responsibilities for the operation and administration of the Plan. The Plan Administrator shall have the authority to

amend or terminate the Plan, to determine its policies, to appoint and remove service Providers, adjust their compensation (if any), and exercise general administrative authority over them. The Plan Administrator has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder.

This document serves as both the written Plan Document and the Summary Plan Description ("SPD") required under ERISA. This document summarizes the Plan rights and benefits for eligible Employees and their Dependents and is divided into the following parts:

Medical Benefits Schedule. 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.

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 Plan Participant 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.

The Plan is obligated to pay Clean Claims.

Plan Administrator.

Port Health Services Group Health Plan is the benefit plan of Port Health Services, 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 Port Health Services, 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, Port Health Services 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.

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. Should there be any conflict between the law and Plan provisions, the law will prevail.

Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Plan Participant and beneficiaries receive a summary of any change that is a "Material Reduction in Covered Services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978. Most employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent Spouse of an Employee.

Family and Medical Leave Act of 1993 ("FMLA"). So long as the Employer and the applicable Employer division is subject to FMLA, if a Plan Participant ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

Omnibus Budget Reconciliation Act of 1993 ("OBRA"). OBRA 1993 requires that an eligible Dependent child of an Employee will include a child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a child for whom the Employee or covered Dependent Spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Plan Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

Newborns' and Mothers' Health Protection Act of1996. The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows: All applicable benefit provisions still apply, including existing Deductibles, Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. In the case of an Employee or Dependent who receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and who elects breast reconstruction (in a manner determined in consultation with the attending Physician and the Plan Participant), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage and will be provided in consultation with the Plan Participant and the attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test aspart of a research study as long as the results are not used for underwriting purposes.
3. Requesting, requiring, or purchasing Genetic Information for underwriting purposes (which includes

eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal, or replacement of coverage). The Plan is also prohibited from requesting, requiring, or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes. GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA? Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes);
2. The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling, or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

Medicaid and The Children's Health Insurance Program ("CHIP"). Offer Free Or Low-cost Health Coverage To Children And Families. If a Plan Participant is eligible for health coverage from their Employer, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage but need assistance in paying their health premiums. If the Employee or eligible Dependents aren't eligible for Medicaid or CHIP, they won't be eligible for these premium assistance programs, but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If the Employee or eligible Dependents are already enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office to find out if premium assistance is available. If the Employee or eligible Dependents are NOT currently enrolled in Medicaid or CHIP, and they might be eligible for either of these programs, the State Medicaid or CHIP office can be contacted, or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent special enrollment period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this special enrollment, the Employee must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

If a state in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

ARTICLE II
OVERVIEW OF BENEFITS

Verification of Eligibility (800) 634-0173

Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

MEDICAL BENEFITS

All benefits described in the Medical Benefits 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 do not exceed the Maximum Allowable Amount, 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 Plan.

This Plan 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 there are questions about specific supplies, treatments, or procedures.

Precertification of certain services is required by the Plan. Precertification provides information regarding Medical Necessity before the Plan Participant receives treatment, services, or supplies. ***A Precertification of services by J.P. Farley is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and Exclusions of the Plan at the time services are provided.***

All services requiring Precertification, as noted in the Summary Plan Description are to be certified in advance by the Utilization Review Department, except for emergencies. The Plan Participant or their Authorized Representative is required to contact J.P. Farley for Precertification located on the back of their ID card for the services specified in the Medical Benefits Schedule at least 3 business days prior to the services being rendered. The Plan Participant or their Authorized Representative must identify the services to be rendered and the associated Diagnosis and procedure codes necessary for Precertification determinations and service prepricing.

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 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Diagnostic Testing: (See FOCUS List)
Dialysis Treatment
Durable Medical Equipment (over $1,500)
Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy)
High-risk maternity and Routine maternity (routine only if the stay exceeds Federal requirements)
Home Health Care
Hospice Care
Infusion Therapy
Inpatient Hospitalizations
Inpatient Mental Health (MH) & Substance Abuse (SA)
Manipulative/Chiropractic Services
Orthotic/Prosthetics
Outpatient surgeries (see FOCUS List)
Rehabilitation (including Cardiac and Pulmonary)
Skilled Nursing Facility
Transplant

Contact J.P. Farley Corporation at (800) 634-0173 to Pre-certify a non-emergency admission and services.

GENERAL SERVICES NETWORK PROVIDERS

The Plan utilizes a Network Provider Organization for services eligible under the Medical Benefits section of the Plan. The Network Provider Organization is applicable only to the Medical Benefits section of the Plan.

The Hospitals, Physicians, and other health care Providers, through their participation in the Network Provider Organization, have agreed to render services to Plan Participants and accept as payment in full, the amounts specified in the agreements they have entered into with the Network Provider Organization.

In some instances, the Plan Administrator may have direct contracts or agreements in place with certain providers that are outside of the Network Providers. Plan Participant's should contact the Claims Administrator for additional information.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Medcost PPO
Address: P.O. Box 25307
Winston-Salem, NC 27114

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 Plan Participants, the Plan can afford to reimburse a higher percentage of their fees.

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

Under the following circumstances, the higher Network Provider payment will be made for certain non-network services:

1. If a Plan Participant has no choice of Network Providers in the
2.
3.
4. that the Plan Participant is seeking within the PPO service area.

5. If a Plan Participant is out of the PPO service area and has a Medical Emergency requiring immediate care.

6. If a Plan Participant receives Physician or anesthesia services by a non-Network Provider at a 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.

Please contact the J.P. Farley Corporation at (800) 634-0173 for a list of Network Providers.

ARTICLE III
MEDICAL BENEFITS SCHEDULE

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Network and non-Network maximums are separate and do not accumulate towards each other. **The Maximum Allowable Non-Contracted Amount for all non-Network Providers is 150% of the Medicare fee schedule on the applicable date of service.**		
DEDUCTIBLE, PER PLAN YEAR		
Single Coverage	$5,000	$10,000
Family Coverage	$10,000	$20,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR		
Single Coverage	$6,850	$13,700
Family Coverage	$13,700	$27,400
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The Maximum Out-of-Pocket Amount includes Coinsurance, Copayments and Deductibles applied toward covered medical and prescription benefits as shown above. The following charges do not apply toward the Maximum Out-of-Pocket Amount and are never paid at 100%: • Cost containment penalties; • Amounts over the Maximum Allowable Amount; or • Amounts related to non-Covered Charges.		
	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Failure to Obtain Precertification	None	Reduction in benefits up to 50%
Hospital Services- *Precertification Required*		
Room and Board	70% after Deductible is met Semiprivate room rate	40% after Deductible is met Semiprivate room rate
Intensive Care Unit	70% after Deductible is met Hospital's ICU Charge	40% after Deductible is met Hospital's ICU Charge
Inpatient Services	70% after Deductible is met	40% after Deductible is met
Physician/surgeon fees	70% after Deductible is met	40% after Deductible is met
Medical Emergency		
Emergency Room- Medical Emergency	50% after Deductible is met	
Emergency Room- Non Medical Emergency	Not Covered	
Emergency- Medical Transportation	70% after Deductible is met	
Urgent Care Facility	$75 Copayment	40% after Deductible is met
Skilled Nursing Facility 60 day per Plan Year *Pre-certification is required*	70% after Deductible is met Semiprivate room rate	40% after Deductible is met Semiprivate room rate
Physician Services		
Office Visits (Primary Care, Pediatrician and Gynecologist) (Covers all services performed by the physicians office)	$35 Copayment	40% after Deductible is met
Specialist Office Visits	$75 Copayment	40% after Deductible is met

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Allergy Care (includign testing, serum, and injection with an office visit charge	Physician: $25 Copayment Specialist: $55 Copayment	40% after Deductible is met
Allergy Serum and Injections (without an office visit charge)	50% after Deductible is met	40% after Deductible is met
Surgical Services-*Precertification Required*		
Facility Fee (e.g. ambulatory surgery center)	50% after Deductible is met	40% after Deductible is met
Physician/surgeon fees	50% after Deductible is met	40% after Deductible is met
Diagnostic Testing (Lab, X-ray)	70% after Deductible is met	40% after Deductible is met
Diagnostic Testing (MRI/CT/PET scans) *Complex Images require precertification*	70% after Deductible is met	40% after Deductible is met
Home Health Care- **Precertification required*	70% after Deductible is met	40% after Deductible is met
Hospice Care 60 visits per plan year **Precertification required*	70% after Deductible is met	40% after Deductible is met
Pregnancy/Maternity Services- *Dependents other than Spouses are not covered under this benefit except for Preventive services as required by federal law.*		
Office Visits	50% after Deductible is met	40% after Deductible is met
Childbirth/Delivery: Professional Services	70% after Deductible is met	40% after Deductible is met
Childbirth/Delivery: Facility Services	70% after Deductible is met	40% after Deductible is met
Rehabilitation and Habilitation Services *Pre-certification is required*		
Physical Therapy 30 visits per Plan year	$75 Copayment	40% after Deductible is met
Speech Therapy 30 visits per Plan year	$75 Copayment	40% after Deductible is met
Occupational Therapy 30 visits per Plan year	$75 Copayment	40% after Deductible is met
Spinal Manipulation/ Chiropractic Services *20 visits per Plan year	$75 Copayment	40% after Deductible is met
Cardiac Rehabilitation *Pre-certification is required*	50% after Deductible is met	40% after Deductible is met
Pulmonary/Respiratory Therapy 30 visits per Plan year	$75 Copayment	40% after Deductible is met

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Durable Medical Equipment *If Rented, limited to the Allowable Charge for the purchase pric of the item. If purchased, limited to a single purchase of a type of Durable Medical Equipment (including repair/replacemnt) every 3 years; limit not applicable to wound vacuums. **Precertification required*	50% after Deductible is met	40% after Deductible is met
Prosthetics/Orthotics Prosthetics are limited to 1 permanent prosthetic device, unless necessary due to growing child's functional need. **Precertification required*	50% after Deductible is met	40% after Deductible is met
Wig after Chemotherapy	50% after Deductible is met	40% after Deductible is met
Routine Vision Exam 1 routine eye exam every 2 years	No Charge	40% after Deductible is met
Mental Health Services- *Inpatient requires precertification*		
Inpatient	70% after Deductible is met	40% after Deductible is met
Office Visit	$35 Copayment	40% after Deductible is met
Outpatient	50% after Deductible is met	40% after Deductible is met
Substance Abuse Services- *Inpatient requires precertification*		
Inpatient	70% after Deductible is met	40% after Deductible is met
Office Visit	$35 Copayment	40% after Deductible is met
Outpatient	50% after Deductible is met	40% after Deductible is met
Preventive Care		
Certain Preventive Care services are provided as specified by the Patient Protection and Affordable Care Act (ACA) at no cost sharing to the Plan Participant. These services are based on age, gender, and other health factors. A current list of covered services can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits or by calling (800) 634-0173.		
Preventive Care Services	100%, deductible does not apply	Not Covered

ARTICLE IV
PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT	
	PARTICIPATING
Pharmacy Option (Up to 31 Day Supply)	
Generic Drugs	Preferred Network: $5 Copayment Wrap Network: Walgreens CVS, etc.: $15 Copayment
Formulary Brand Name Drugs	Preferred Network: $25 Copayment Wrap Network: Walgreens CVS, etc.: $45 Copayment
Non-Formulary Brand Name Drugs	Preferred Network: $50 Copayment Wrap Network: Walgreens CVS, etc.: $60 Copayment
Specialty Drugs	Preferred Network: 75% Retail Only Wrap Network: Walgreens CVS, etc.: 50% cost of medication-Retail only
Mail Order Option (90 Day Supply) Note that not all Specialty Drugs are available with a 90-day supply, and special pricing may apply.	
Generic Drugs	Preferred Network: $5 Copayment Wrap Network: Walgreens CVS, etc.: $15 Copayment
Formulary Brand Name Drugs	Preferred Network: $25 Copayment Wrap Network: Walgreens CVS, etc.: $45 Copayment
Non-Formulary Brand Name Drugs	Preferred Network: $50 Copayment Wrap Network: Walgreens CVS, etc.: $60 Copayment
Specialty Drugs	NA
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.	
ACA Preventive Drugs and Contraceptives are covered under the Preventive Care benefit as required by ACA.	

ARTICLE V
SPECIALIZED SERVICES BENEFIT SCHEDULE

SPECIALIZED SERVICES BENEFIT	
Specialty Pharmaceuticals *Over $1,250 Specialty Pharmaceutical Drugs are excluded under this Plan. Notwithstanding the foregoing, the Plan will cover the charges for a Specialty Pharmaceutical Drug for the first 30-day fill of any Specialty Pharmaceutical that is self-administered and filled at a licensed pharmacy, or the first dose of any Specialty Pharmaceutical administered in a hospital, facility or provider's office administered by a healthcare professional for each Specialty Pharmaceutical Drug, unless otherwise excluded elsewhere in the Plan.	All approved and covered treatments will be paid at 50% after deductible of the respective Maximum Allowable Contracted Amount. Subject to precertification.
Dialysis (Kidney dialysis limited to 42 lifetime treatments)	All approved and covered treatments will be paid at 50% after deductible of the respective Maximum Allowable Non-Contracted Amount, which is 150% of the current Medicare fee schedule. Non Network is not covered. Subject to precertification.
Organ Transplants	All pre-certified and approved services will be paid at 50%, no deductible if a contracted provider is utilized. Pre-certified and approved services are covered at a 40% after deductible for Non Network. Subject to precertification.
Radiation/ Chemotherapy	All pre-certified and approved services will be paid at 50%, no deductible if a contracted provider is utilized. Pre-certified and approved services are covered at a 40% after deductible for Non Network. Subject to precertification.
Infusion Therapy	All pre-certified and approved services will be paid at 50%, no deductible if a contracted provider is utilized. Pre-certified and approved services are covered at a 40% after deductible for Non Network. Subject to precertification.

ARTICLE VI
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

A Plan Participant should contact the Claims 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.

Eligible Classes of Employees.

- All Active 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 30 hours per week and is on the regular payroll of the Employer for that work; and

(2) Is in a class eligible for coverage; and

(3) Completes the employment Waiting Period of XX days from the date of employment as an Active Employee.

Coverage will begin the first day of the calendar month following or coinciding with the completion of all eligibility requirements, active employee requirement, and enrollment requirements as stated under this Plan.

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.

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

(1) A covered **Employee's Spouse and children** from birth through the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the date of the child's birthday.

The term **"Spouse"** means a person recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized. The Plan Administrator may require documentation proving a legal marital relationship.

The term **"children"** shall include natural children, adopted children, children placed with a covered Employee in anticipation of adoption and stepchildren.

If a covered Employee is the **Legal Guardian** of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase **"child placed with a covered Employee in anticipation of adoption"** refers to a child whom the Employee 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 Employee 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.

Any child of a Plan Participant who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Plan Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child 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 during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's 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 home, but who are not eligible as defined; domestic partners, the legally separated or divorced former Spouse of the Employee; Foster Children; or any person who is covered under the Plan as an Employee.

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 parents are Employees, their eligible Dependent will be covered as the Dependent of one or the other, 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.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following or coinciding with the date that the Employee satisfies all of the following:

(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.

FUNDING

Cost of the Plan. Port Health Services shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

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 each Dependent for coverage also.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who is currently enrolled with Dependent coverage will not be automatically enrolled from the date of birth.

The Employee will be required to enroll the newborn child on a timely basis, as defined in the section "Timely Enrollment" following this section, or there will be no further payment from the Plan and the parents will be responsible for all costs.

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 who are covered under the Plan are the parents of children who 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. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a special enrollment period may join only during open enrollment.

Unless otherwise required by law, 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 as specified in the Open Enrollment section.*

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).

In addition, if an Employee or his or her Dependents (including his or her Spouse) is losing coverage due to a loss of a government sponsored subsidy (due to ineligibility for coverage or cost of coverage) there may be a right to enroll in this Plan.

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.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. The events described below may create a right to enroll in the Plan under a special enrollment period.

(1) Losing other coverage may create a special enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and 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 of loss.

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 of loss.

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 (for example: 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.

(2) Acquiring a newly eligible Dependent may create a special enrollment right. If:

a. The Employee is a Plan Participant under this Plan (or has met the Waiting Period applicable to becoming a Plan 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 31days 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 31-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.

(3) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right. 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.

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The Day 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.

(3) 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.

(4) 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.

Note: 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 COBRA Continuation Coverage.

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

For Approved Disability Leave: (not meeting the definition of FMLA) up to the end of the 12 week period that next follows the date in which the person last worked as an Active, Full-time employee. Approved disability leave provisions and limitations are addressed in the Employee Handbook (if applicable) or as administered by employer. If FMLA is applicable, Approved Disability Leave runs concurrently with FMLA.

For Approved Leave of Absence: (not meeting the definition of FMLA) up to the end of the 12 week period that next follows the date in which the person last worked as an Active, Full-time employee. Approved leave of absence provisions and limitations are addressed in the Employee Handbook (if applicable), or as administered by the employer. If FMLA is applicable, Approved Leave of Absence runs concurrently with FMLA. 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.

Extended Leave of Absence – Port Health Services has an Extended Leave of Absence Policy. The policy allows for an extension of time for an already approved leave of absence. If you are on an approved leave of absence, the company will under certain circumstances approve your leave to be extended through a period of time not to exceed (6) six months. The extension must be approved by the Vice President of Construction Services. Please see contact Human Resources for the definitions and procedures that apply to Extended Leave of Absence and return to work provisions.

Medical Leave of Absence (Non-FMLA) A non-FMLA medical leave must be approved by human resources and should not extend beyond 3 months. This leave is permitted only for those employees who do not yet qualify for FMLA leave. This leave follows the same guidelines as an approved FMLA leave in regard to benefits, premiums, notification of leave, updates while on leave, etc. Failure to return to work at the end of the leave or within 3 months will result in termination of employment.

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, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations.

This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employee and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the Family and Medical Leave Act and/or other State leave law, 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 and/or other State leave law. 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. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, unless otherwise required by applicable law.

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 covered 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 at:

Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

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 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 Day the Plan or Dependent coverage under the Plan is terminated.

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

(4) The end of the period in which the qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

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.

ARTICLE VII
OPEN ENROLLMENT

Each year there is an annual open enrollment period designated by the Plan Administrator during which Plan Participants may change their benefit elections under the Plan, and Employees and their Dependents, who are Late Enrollees, will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective November 1. Plan Participants will receive detailed information regarding open enrollment from the Plan Administrator.

Benefit choices made during open enrollment will remain in effect until the next open enrollment period 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 coverages.

ARTICLE VIII
MEDICAL BENEFITS

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

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year, a Plan Participant must meet the individual Deductible shown in the Medical Benefits Schedule.

The Deductible will apply to the Maximum Out-of-Pocket Amount.

Embedded Deductible. This Plan has an "embedded" Deductible, which means a covered family member only needs to satisfy his or her individual Deductible, not the entire family Deductible, prior to the Plan paying benefits for that individual.

However, the Deductible amount for all members of that Family Unit will only be satisfied when the family Deductible has been met for that Plan Year or each individual member has satisfied his/her individual Deductible amount.

Family Unit Limit. When the maximum amount shown in the Medical Benefits Schedule has been Incurred by members of a Family Unit toward their Plan Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

All benefits under this Plan are payable, in U.S. Dollars, to the Plan Participant whose Illness or Injury is the basis of a Claim, unless the Plan Participant gives written direction, at the time of filing a Claim, to pay directly the Hospital or Physician rendering such medical care. The Plan Participant, in accordance with the terms of this Plan, compensates Hospital or Physician of medical care with such an Assignment of Benefits. Payment of benefits from the Plan to a health care Hospital or Physician pursuant to written direction of the Plan Participant is subject to the approval of the Plan Administrator and shall be made as consideration in full for services rendered. In the event of the death or incapacity of a Plan Participant and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Plan Participant.

MAXIMUM OUT-OF-POCKET AMOUNT

Covered Charges are payable at the percentages shown each Plan until the Maximum Out-of-Pocket Amount shown in the Medical Benefits Schedule is reached. Then, Covered Charges Incurred by a Plan Participant will be payable at 100% (except for any charges excluded as detailed in this Plan) for the rest of the Plan Year.

COVERED CHARGES

Covered Charges are the Maximum Allowable Amounts that are Incurred for the following items of services and supplies when Medically Necessary to diagnose or treat a Plan Participant. These charges are subject to all 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.

A. **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Medical Benefits Schedule. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Medical Benefits Schedule.

B. Coverage of Pregnancy. The Maximum Allowable Amounts for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Employee or covered Spouse. Dependents other than Spouses are not covered under this benefit except for preventive services as required by Federal law.

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 96 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 48 hours (or 96 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 48 hours (or 96 hours).

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

1. The Plan Participant is confined as a bed patient in the facility; and

2. The confinement starts immediately following a Hospital confinement or a period of Home Health Care utilization; and

3. The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

4. 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 Plan Participant's care in these facilities are payable as described in the Medical Benefits Schedule.

D. 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:

1. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowable Amount that is allowed for the primary procedures; 50% of the Maximum Allowable Amount 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;

2. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Amount 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 Maximum Allowable Amount allowed for that procedure; and

3. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Maximum Allowable Amount.

E. 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. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

F. Home Health Care Services and Supplies. Charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Medical Benefits Schedule.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

G. Hospice Care Services and Supplies. Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Plan Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Medical Benefits Schedule.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the Plan Participant's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the Plan Participant's death.

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

1. **Allergy Testing/Allergy Injection**. Medical Benefit Covered Services are provided for allergy testing consisting of percutaneous, intracutaneous, and patch tests, allergy extracts, and antigen injections.

   Medical Benefit Covered Services are provided for blood testing, only if:
   - Direct skin testing is not possible because the Covered Person has extensive dermatitis;
   - Direct skin testing is not possible because the Covered Person is under the age of five (5); or
   - There is a history of severe anaphylactic allergy (bee sting, penicillin, etc.).

   As used here, “blood testing” includes, but is not limited to: (a) RAST; (b) PRIST; and (c) RIST. In no cases will charges to duplicate the RAST test be covered.

2. 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.

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

4. **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.

5. Radiation and **Chemotherapy** and treatment with radioactive substances. The Materials and services of technicians are included.

6. Routine patient care charges for **Clinical Trials.** Coverage is provided only for routine patient care costs for a qualified individual in an approved clinical trial for treatment of cancer or other life-threatening Disease or condition. For these purposes, a qualified individual is a Plan Participant who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening Disease or condition, and either: (1) the referring health care professional is a Network Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Plan Participant provides medical and scientific information establishing to the satisfaction of the Plan Administrator that the individual's participation in such trial would be appropriate. Coverage is not provided for charges not otherwise covered under the Plan and **does not include** charges for the drug or procedure under trial, or charges which the qualified individual would not be required to pay in the absence of this coverage.

7. Initial **contact lenses** or glasses required following cataract surgery.

8. **Dental services** related to Accidental Injury.

9. Rental of **Durable Medical 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.

10. **Emergency Services.** Covered Services include Emergency Services for a Medical Emergency. Visits performed in the Outpatient department of a Hospital that are follow-up to Emergency Services for a Medical Emergency are classified and payable as Outpatient Covered Services.

    In the case of Emergency Services for a Medical Emergency delivered by an Out-of-Network Provider, Covered Services are considered under the In-Network level of benefits and paid at a "Reasonable Amount" to the Out-of-Network Provider.

    Charges for the use of an emergency room for a non-Medical Emergency are not covered.

11. **Infusion Therapy.** The IV administration of therapeutics-including analgesics, antibiotics chemotherapy, parenteral nutrition-outside of a formal healthcare environment.

12. Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ).** Charges for TMJ are subject to the limits as described in the Schedule of Benefits.

13. **Kidney Dialysis.** Charges for professional fees and services, supplies, medications, labs, and facility fees related to outpatient dialysis are covered expenses. These services include but not limited to Hemodialysis, Home Hemodialysis, Peritoneal Dialysis and Hemofiltration.

    From the initial outpatient dialysis treatment, regardless of the member's enrollment date with this plan, through the next 42 outpatient lifetime treatments, the plan will pay in accordance with the major medical contained in this plan, subject to HIPAA requirements. In-network providers will be paid at the preferred level. No benefits will be paid for out of network providers.

14. **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

15. Treatment of **Mental or Nervous Disorders and Substance Abuse**. Regardless of any limitations on benefits for Mental or Nervous Disorders and Substance Abuse treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion, or non-quantitative treatment limitation on Mental or Nervous 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 or Nervous Disorders and Substance Abuse will be limited as follows:

    All treatment is subject to the benefit payment limits shown in the Medical Benefits Schedule.

    Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Master 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.

16. 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 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.

    Reduction of dislocations and excision of temporomandibular joints (TMJs).

    No charge will be covered 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.

17. **Occupational therapy** by a licensed therapist. Therapy must be ordered by a Physician, result from an Injury or Illness, and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

18. **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 these limits:

    The transplant must be performed to replace an organ or tissue.

    Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
    - evaluating the organ or tissue;
    - removing the organ or tissue from the donor;

- and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

19. The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Illness.

20. **Physical therapy** by a licensed 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.

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

22. Routine **Preventive Care.** Covered Charges are payable for routine Preventive Care as described in the Medical Benefits Schedule. Standard Preventive Care shall be provided as required by applicable law if provided by a Network 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:
    - Breastfeeding support, supplies, and counseling.
    - Gestational diabetes screening.

Standard Preventive Care includes women's contraceptives sterilization procedures, and counseling.

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:

1. 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 Illness.

Charges for Routine Well Child Care. Routine well childcare is routine care by a Physician that is not for an Injury or Illness. Standard Preventive Care shall be provided as required by applicable law if provided by a Network 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:

2. 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/

23. The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

24. Reconstructive Surgery. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

a. Reconstruction of the breast on which a Mastectomy or Lumpectomy has been performed,

b. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

c. Coverage of prostheses and physical complications during all stages of Mastectomy or Lumpectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the Plan Participant.

25. Respiratory/Pulmonary Therapy. Treatment by the introduction of dry or moist gases into the lungs, including but not limited to inhalation treatment (pressurized and non-pressurized) for acute airway obstruction or sputum induction for diagnostic purposes.

26. Speech Therapy by a licensed speech therapist / audiologist. 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.

27. Spinal Manipulation/Chiropractic services by a health care Provider acting within the scope of his or her license.

28. Sterilization procedures.

29. Surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations.

30. 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 well-baby 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 Plan Participant 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 Maximum Allowable Amount for routine well-baby 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 newborn child, provided the newborn child is enrolled on a timely basis.

    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 96 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 48 hours (or 96 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 48 hours (or 96 hours).

    Charges for covered routine Physician care will be applied toward the Plan of the newborn child, provided the newborn child is enrolled on a timely basis

31. **Urgent Care Services.** Covered Services include Outpatient services and supplies provided by an Urgent Care Facility and Professional Provider for treatment of an unforeseen illness or injury that is not life threatening. The condition does, however, require prompt medical attention to prevent a serious deterioration in the Covered Person’s health.

32. Charges associated with the initial purchase of a **wig after chemotherapy**.

33. Diagnostic **x-rays**.

I. **Charges for Vendors:** Charges for services related to adjusting billed charges to amounts allowable by the Plan, including network fees, maximum allowable costs, subrogation recoveries, bill reviews and audits, care management, Disease management, outside counsel fees and other items of a similar nature

ARTICLE IX
SPECIALIZED SERVICES BENEFITS

This section applies to all charges incurred by a Covered Person for treatment and care of the specific sicknesses as outlined below. All services for treatment of the specific sicknesses outlined above must be pre-certified and approved.

All pre-certified and approved services will be subject to deductible and payable at 50% of the approved amounts at the Maximum Allowable Amount. If services are not approved and are rendered by a provider who has not entered into an agreement to provide Specialized Services to Plan Participants, the Plan's responsibility for payments shall be limited to the Maximum Allowable Non-Contracted Amount of 40% after deductible.

Dialysis Benefit

Reimbursement for Dialysis Benefit is paid under the Specialized Service Benefit. This benefit includes Dialysis, Hemodialysis and Peritoneal Dialysis. Dialysis treatment is subject to the pre-certification requirement. Pharmaceuticals are covered under the Pharmaceutical section of the plan. All approved and covered treatments will be subject to deductible and payable at 50% of the respective Maximum Allowable Non-Contracted Amount, which is 150% of the current Medicare fee schedule. Non Network is not covered.

Radiation Benefit

Reimbursement for Radiation Benefit is paid under the Specialized Service Benefit. Radiation treatment is subject to the pre-certification requirement. Pharmaceuticals are covered under the Pharmaceutical section of the plan. All approved and covered treatments will be subject to deductible and payable at 50% of the respective Maximum Allowable Non-Contracted Amount, which is 150% of the current Medicare fee schedule. Non Network will be covered at 40% after deductible.

Transplant Benefit

For those procedures requiring an Organ Transplant, the Participant is to use an "organ transplant network" as determined by the Plan Supervisor. Guidance as to appropriate providers of service will be given to the Participant by J.P. Farley Corporation. In order for this process to be initiated, the Participant must preauthorize the Organ Transplant and enter into care management. When the organ transplant network is utilized and preauthorization in accordance with the plan benefit is obtained, the Covered Transplant Procedure shall be paid at 100% after deductible. Failure to utilize an "organ transplant network" shall result in payment for services at 100% of the Maximum Allowable Non-Contracted Amount after deductible.

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 these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Associated Travel Expenses Related to a Covered Transplant Procedure:

When the Covered Person receiving the transplant resides more than fifty (50) miles from the transplant site, Associated Travel Expenses will be covered under the Plan. Associated Travel Expenses shall include:

(1) Commercial transportation to and from the site of the transplant for the Covered Person receiving the transplant and one (1) companion; and

(2) Reasonable and customary lodging and meal costs incurred by the Covered Person and one (1) companion. Reasonable and Customary lodging and meal costs are limited to $250.00 per day for the Covered Person and one (1) companion.

Transportation, lodging, and meal costs are limited to an aggregate maximum of $10,000.00 per transplant episode for the Covered Person and one (1) companion.

Unrelated donor searches for bone marrow/ stem cell transplants for a Covered Transplant Procedure benefit limit is $30,000.00.

In the event a Covered Person is balance billed from a provider and/or facility, please refer to the Patient Advocacy Program set forth above.

ARTICLE X
PATIENT ADVOCACY PROGRAM

The Plan has developed a Patient Advocacy Program in order to assist Plan Participants with charges that are billed in error, charges that are in excess of the Plan's Maximum Allowable Charge and/or Maximum Allowable Amount, and charges that are unreasonable for the services and treatment provided.

Plan Participants are responsible for any normal cost-sharing amounts such as Deductibles, Coinsurance, Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan.

As a Plan Participant, in the event of being balance billed by a Provider and/or a facility beyond the applicable cost-sharing amounts set forth in the Plan, please contact the Claims Administrator immediately at the number set forth below.

J.P. Farley Corporation
29055 Clemens Road
Westlake, Ohio 44145
(800) 634-0173

The success of the Patient Advocacy Program is entirely dependent upon participation and cooperation. As soon as the Plan Participant receives any indication that they are going to be balance billed by a Provider and/or facility, contact the Claims Administrator immediately at the number set forth above. If a bill from the Provider and/or facility is received, please immediately send a copy to:

J.P. Farley Corporation
29055 Clemens Road
Westlake, Ohio 44145
(800) 634-0173

Once the Claims Administrator has been properly notified that a Plan Participant is being balance billed from a Provider and/or facility, the Patient Advocacy Program will be implemented. The Plan Participant will receive a call from the Claims Administrator explaining the entire process. The Plan Participant will be required to participate in the advocacy process and cooperate with the Claims Administrator. In the event the Plan Participant is turned over to collection, the Plan will retain legal counsel on behalf of the Plan Participant so long as the Plan Participant has participated and cooperated throughout the entire process. In the event the Plan Participant fails to participate and cooperate in the Patient Advocacy Program, the Plan Participant may be responsible for any balance billed amount and/or any corresponding legal action.

ARTICLE XI
COST MANAGEMENT SERVICES

Cost Management Services Phone Number:

(800) 634-0173

The Provider, Plan Participant or family member must call this number to receive certification of certain cost management services. This call must be made at least 72 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

Any costs Incurred because of reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% Maximum Out-of-Pocket Amount.

UTILIZATION REVIEW

Utilization Review is a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided:

Diagnostic Testing: (See FOCUS List)
Dialysis Treatment
Durable Medical Equipment (over $1,500)
Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech)
High-risk maternity and Routine maternity (routine only if the stay exceeds Federal requirements)
Home Health Care
Hospice Care
Infusion Therapy
Inpatient Hospitalizations
Inpatient Mental Health (MH) & Substance Abuse (SA)
Manipulative/Chiropractic Services
Orthotic/Prosthetics
Outpatient surgeries (see FOCUS List)
Rehabilitation (including Cardiac and Pulmonary)
Skilled Nursing Facility
Transplant

FOCUS PROCEDURES:

Back and Spinal Surgery
Bronchoscopy
Bunionectomy
Carotid Endarterectomy
Cataract Removal and/or Lens Insertion
Cholecystectomy
Coronary Artery Bypass Surgery
Cystourethroscopy
Dilation and Curettage (D&C)
EGD
Epidural injections/ Facet Blocks Injections
Hammertoe Repair
Heart Catheterization

Hemorrhoidectomy
Hip Replacement
LAUP Procedures
Ligation and/or Stripping of vein in the legs
Meniscectomy
Osseointegrated, Cochlear or Auditory Brain Stem Implant
Pacemaker / Defibrillator
Pelvic Laparoscopy
Prostatectomy / Prostate Surgery
Rhinoplasty/Septoplasty
Strabismus Repair
Total Joint Replacement
Upper Gastrointestinal (UGI) Endoscopy
Uvulectomy
Varicose Vein Surgery
Adenoidectomy
Cat Scans
Cat Scan Angiography (CTA)
Diagnostic Bone Density Scan
Diagnostic Colonoscopy
Magnetic Resonance Imaging (MRI)
Magnetic Resonance Angiogram (MRA)
Nuclear Scans
Pet Scans
Sleep Studies

(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 Plan Participant 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 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

Here is how the program works.

Precertification. Before a Plan Participant enters a Medical Care Facility on a non-emergency inpatient basis or receives the other medical services listed above, 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 Plan Participant. Contact the Utilization Review administrator at the telephone number on the Plan Participant's ID card **at least 72 hours before** services are scheduled to be rendered with the following information:

- The name of the Plan Participant 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

If there is an **emergency** admission to the Medical Care Facility, the Plan Participant, Plan Participant'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.**

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 Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant 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 Plan Participant 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 Participants 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 Illness.

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

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow, or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy

Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

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.

OUTPATIENT SURGERY

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

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 Plan Participant, 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 Plan Participant, the family, and the attending Physician in order to develop a Plan of Care for approval by the Plan Participant's attending Physician and the Plan Participant. This Plan of Care may include some or all of the following:

-- Personal support to the Plan Participant;

-- 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 Plan Participant 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, Plan Participant and Plan Participant'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 Plan Participant and family choose not to participate.

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

ARTICLE XII
DEFINED TERMS

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

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Active Employee means 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.

Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a Claim that is based on any: (a) determination of an individual's eligibility to participate in a Plan or health insurance coverage; (b) determination that a claimed benefit is not a covered benefit; (c) imposition of a source-of-injury exclusion, or other limitation on otherwise covered benefits; (d) determination that a claimed benefit is Experimental, Investigational, or not reasonable, Medically Necessary or appropriate; (e) Invalid Charges; or (f) as otherwise defined in the Plan Document.

Assignment of Benefits means an arrangement whereby the Plan Participant assigns the right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of the Plan, to a Provider.

Authorized Representative means a person designated by the Claimant to act on his or her behalf and communicate with the Plan with respect to a specific benefit Claim or appeal of a denial. This authorization must be made in writing, signed, and dated by the Claimant, and include all information required in the Authorized Representative form.

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.

Claim means a request for a Plan benefit, made by a Claimant (Plan Participant or by an Authorized Representative of a Plan Participant that complies with the Plan's Reasonable procedures for filing benefit Claims).

Claimant means an Employee or Dependent who is covered under this Plan, sometimes referred to in this Plan Document as a Plan Participant.

Claims Administrator means J.P. Farley Corporation.

Clean Claim means a Claim form which has no defect or impropriety; does not lack any required substantiating documentation per the applicable health benefit plan necessary to enable the Claims Administrator to determine whether a health care service or the recipient of such service is a Covered Service or Plan Participant as defined in this Agreement; does not contain a defect that requires an investigation; or does not involve any particular circumstances requiring special treatment per the health benefit plan that prevents timely processing.

A Clean Claim must be submitted on a UB92 form (or its successor) and accurately contains all the following information: Plan Participant name, Plan Participant's date of birth, Plan Participant's identification number, Hospital's name, address and tax ID number, date(s) of service or purchase, diagnosis narrative or ICD-9 code, procedure narrative or CPT-4 code, services and supplies provided, Physician's name and license number, the Hospital's charges and any other attachments or information mutually agreed upon in writing by the Parties.

A Clean Claim has no billing Errors. Examples of billing Errors include but are not limited to duplicate charges, charges for supplies, medications, tests, or services that were not ordered or received, unbundled charges, charges for services that should be included in the room charge, charges for services that the Plan Participant refused, data entry, coding or keying Errors, inaccurate operating room time, inaccurate number of days as admitted patient, and line items that do not meet criteria for appropriateness or exceed the Maximum Allowable Amount of the Plan (as defined in the Plan).

Prompt payment deadlines will be initiated upon receipt of a Clean Claim, and all required substantiating documentation.

A Claim exceeding $5,000 requires that an itemized bill be provided to the Plan before it can be considered a Clean Claim.

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

Coinsurance means the Plan Participant's share of the costs of a Covered Charge.

Complications of Pregnancy are determined as follows: These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.

Other Pregnancy related conditions will be covered that are as medically severe as those listed.

These conditions are not considered a Complication of Pregnancy: false labor; occasional spotting; rest during Pregnancy even if prescribed by a Physician; morning sickness; or like conditions that are not medically termed as Complications of Pregnancy.

Copayment means the fixed amount that the Plan Participant pays for a Covered Charge.

Cosmetic and Reconstructive Services means services which improve appearance or corrects a deformity. If a functional impairment is present and will be corrected through a Cosmetic and Reconstructive Service, then the Cosmetic and Reconstructive Service is considered Medically Necessary. If no functional impairment is present and services are provided solely to restore normal bodily appearance, the service will be considered Medically Necessary only when the defect was caused by a congenital anomaly, Accidental Injury or reconstructive mammoplasty as stated as a benefit under this Plan.

Covered Charge(s) means Provider charges for Covered Services. Covered Charges are billed charges minus non-covered charges and Invalid Charges. Covered Charges also means a reasonable fee for an appropriate, Medically Necessary service, treatment, or supply, meant to improve a condition or Plan Participant's health, which is specified in this benefit Plan as a Covered Charge. Covered Charges will be determined based upon all other Plan provisions.

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

Custodial Care means 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.

Deductible means an amount of money that is paid once a Plan Year per Plan Participant and Family Unit. Typically, there is one Deductible amount per Plan, and it must be paid before any money is paid by the Plan for any medical care. Each Plan Year, a new Deductible amount is required.

Dependent(s) means the Covered Employee's eligible family members as outlined in the eligibility section of this Plan.

Disease means any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any worker's compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness or Disease.

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 Plan Participant.

Employee means a person who is an active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer means each participating Employer in Port Health Services.

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

Errors mean charges based on billing mistakes, improprieties, or illegitimate billing entries including but not limited to up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be Invalid Charges; it is the Plan Administrator's sole discretion to determine what constitutes an Error under the terms of this Plan.

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 means 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 means the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications 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 means 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 Plan Participant'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 Plan Participant.

Home Health Care Services and Supplies means 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 means 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 means 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 means 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 means 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 means an institution which is engaged primarily in providing inpatient diagnostic and therapeutic services at the Plan Participant's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

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

1. 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.

2. 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 Illness or Mental or Nervous Disorder. Illness includes Pregnancy, childbirth, miscarriage, or complications of Pregnancy.

Incurred means that a Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Infertility means incapable of producing offspring.

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

Intensive Care Unit means 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 lifesaving 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.

Invalid Charges means charges (a) that are found to be based on Errors (as identified by this Plan), Unbundling, misidentification or unclear description; (b) charges for fees or services determined not to have been Medically Necessary or reasonable; (c) charges found by the Plan Administrator to be in excess of the Maximum Allowable Charge; (d) charges not covered under the terms of this Plan; or (e) that are otherwise determined by the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard.

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.

Leave of Absence means a Leave of Absence of an Employee that has been approved by his or her Employer, as provided for in the Employer's rules, policies, procedures, and practices.

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.

Lumpectomy means the surgical removal of a small tumor, which may be benign or cancerous.

Mastectomy means the surgical removal of all or part of a breast.

Maximum Allowable Charge and/or Maximum Allowable Amount means the maximum amount reimbursable for services covered by the Plan.

Maximum Allowable Contracted Amount means for purposes of Providers who have entered into agreements with the Plan for providing Specialized Services, Pharmaceutical Benefits, Specialty Pharmaceuticals, Oncology Pharmaceuticals, and Medical Benefits to Plan Participants, the Maximum Allowable Contracted Amount shall be the amount specified in such agreements.

Maximum Allowable Non-Contracted Amount means for all other purposes, the Maximum Allowable Non-Contracted Charge or Maximum Allowable Charge/Amount shall be 150% of the charge allowed by Medicare at the time such services were rendered. If a Provider of service does not participate in Medicare, but the service rendered would otherwise be covered by Medicare, the Maximum Allowable Non-Contracted Amount will be the amount that would have been allowed for a Provider of comparable services that does participate in Medicare. If a service is covered by this Plan, but would not be eligible for reimbursement under Medicare, the Plan will allow the lesser of: an amount that the Plan deems to be comparable to 150% of Medicare for such services; or 20% of the Provider's regularly billed charges for such services. If Provider does not accept Assignment of Benefits as payment in full, benefit will be 100% of the Medicare allowable amount. The Medicare allowable amount is determined based on the date of service.

Maximum Out-of-Pocket Amount means the most that a Plan Participant and/or Family Unit will have to pay for Covered Charges in a Plan Year.

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.

Medically or Dentally Necessary Care and Treatment "Medical Care Necessity", "Medically Necessary", "Medical Necessity", "Dental Care Necessity", "Dentally Necessary", and "Dental Necessity" and similar language refers to health care services ordered by a Physician or dentist exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Illness or Injury or covered dental care. Such services, to be considered Medically Necessary or Dentally Necessary. must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's covered Illness or Injury or covered dental care. The Medically Necessary and Dentally Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical and/or dental symptoms and conditions, cannot be provided in a less intensive medical or dental setting. Such services, to be considered Medically Necessary or Dentally Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's covered Illness or Injury or covered dental need without adversely affecting the Plan Participant's medical or dental condition.

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.
3. It must not be primarily custodial in nature.
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or Maximum Allowable Charge.

For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Plan Participant is receiving or the severity of the Plan Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed, or approved by a Physician does not mean that it is Medically Necessary. In addition, the fact that certain services are excluded from coverage under this Plan because they are not Medically Necessary does not mean that any other services are deemed to be Medically Necessary.

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors or medical advisors to a delegate. The Plan Administrator or its delegate has the discretionary authority to decide whether care or treatment is or was Medically Necessary.

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

Mental or Nervous Disorder means any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous 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 means 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 Plan Participant.

Network Provider means a Provider who has a contract with the Claims Administrator that has agreed to provide less costly services to the Plan Participants.

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

Outpatient Surgical Center means 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 Port Health Services Group Health Plan, which is a benefits plan for certain Employees of Port Health Services and is described in this Plan.

Plan Administrator or Plan Sponsor means the Port Health Services .

Plan of Care means a written plan that describes the services being provided and any applicable short term and long-term goals, specific treatment techniques, anticipated frequency, and duration of treatment, and/or treatment protocol for the Plan Participant's specific condition. The Plan of Care must be written or approved by a Physician and updated as the Plan Participant's condition changes.

Plan Participant means an Employee or Dependent who is covered under this Plan, sometimes referred to in this Plan Document as a Claimant.

Plan Year means the 12-month period beginning on November 1 and ending on the following October 31.

Pregnancy means 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 an Illness or Injury.

Preventive Care means routine care that includes screening, check-ups, and Plan Participant counseling to prevent Illnesses, Disease, or other health problems.

Provider means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Skilled Nursing Facility means 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 Illness. 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 Plan Participants 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, Custodial, or educational care.

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.

Specialty Pharmaceutical means those federal legend drugs that are any drug, regardless of route of administration which are classified by the pharmacy benefit manager as "Specialty" Medications. A drug is considered a "Specialty" medication if it includes one or more of the following characteristics:

- Requires Plan Participant participation in a medication management program that includes review of medication use, patient training, coordination of care and management for successful use
- Continual monitoring and training are needed

- An FDA-mandated Risk Evaluation and Mitigation Strategy program is utilized in order to approve medication
- Medication has particular handling, distribution and/or administration requirements
- Medication has a high cost
- Medication is administered orally, inhaled, infused, or injected
- Medication is used to target chronic or complex Diseases
- Medication can be produced through biological processes
- Medication is used to treat rare Diseases and is referred to as orphan drugs

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 means a person recognized as the covered Employee's husband or wife by the laws of the state in which the marriage was formalized.

Substance Abuse means any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

> A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
>
> a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
>
> b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
>
> c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); or
>
> d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights).

Temporomandibular Joint (TMJ) syndrome means the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means, in the case of a Dependent, the complete inability as a result of Injury or Illness to perform the normal activities of a person of like age and sex in good health.

Unbundling means charging for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

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.

Utilization Review means a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

Waiting Period means the time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible for coverage under the Plan.

ARTICLE XIII
MEDICAL PLAN EXCLUSIONS

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

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

1. **Abortion.** Services, supplies, care, or treatment in connection with an elective or Non-Medically Necessary abortion.

2. **Acupuncture.**

3. **Bariatric Surgery**

4. **Blood and blood plasma.** Charges for blood or blood plasma when credit or refund is or will be made for such items.

5. **Broken / missed appointments.** Charges due to broken or missed appointments.

6. **Completion of forms**. Charges for completing forms, medical, or dental records and any third party questionnaires and other administrative duties not related to the care and treatment of the patient.

7. **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.

8. **Cosmetic Procedures.** Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a Disease state, or improve a physiological function. Cosmetic Procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, Disease, trauma, congenital/developmental Anomalies, or previous covered therapeutic processes.

9. **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care, or domiciliary care consisting chiefly of room and board.

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 Illness that is in excess of the Maximum Allowable Amount.

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. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care of costs a Qualified Individual who is a participant in an approved clinical trial. Charges will be covered only to the extent specifically set forth in the "Covered Charges" section.

14. **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. 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.

15. **Foot Care.** Treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses, or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

16. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, Except for services provided through PriceMD.

17. **Genetic Screening/Testing –** No amounts will be payable for Genetic Screening or pre-implantations genetic screening. General population based genetic screening is a testing method performed in the absence of any symptoms or any significant proven risk factor for a genetically linked inheritable disease.

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, except for wigs after chemotherapy up to the limit shown in the Medical Benefits Schedule.

20. **Hearing Aids and Exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except Preventive Care as may be required under applicable law.

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. **Hyperhidrosis Treatment.**

23. **Hypnotism.**

24. **Illegal Acts.** Charges for services received as a result of Injury or Illness 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" means any act or series of acts that, if prosecuted as a criminal offense, could result in a crime being charges as a misdemeanor or felony under applicable State or Federal law. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

25. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for Impotence. Medically necessary prescriptions, FDA approved, for the care and treatment of impotency/erectile dysfunction, and on the MagallenRX formulary, will be covered under the Prescription Drug Benefit and are not excluded.

26. **Infertility.** Care, supplies, services and treatment for Infertility, artificial Insemination, or in-vitro fertilization, except for the diagnosis of Infertility.

27. **Kidney Dialysis.** No benefits for out of network providers.

28. **Long Term Care.**

29. **Marital or Pre-Marital Counseling.** Care and treatment for marital or pre-marital counseling.

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

31. **Non-Compliance.** All charges in connection with treatments or medications where the Plan Participant either is in non-compliance with medical orders issued while an inpatient at or is discharged against medical advice from a Hospital or Skilled Nursing Facility against medical advice.

32. **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.

33. **No Obligation to Pay.** Charges Incurred for which the Plan has no legal obligation to pay.

34. **No Physician Recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant 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 Illness.

35. **Not Specified as Covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

36. **Nutritional and/or Dietary Supplements**, except as provided in the Plan or as required by law. This includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist

37. **Obesity.** Screening and counseling for obesity will be covered to the extent required under standard Preventive Care. Other 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 Illness is excluded. 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 charges for Morbid Obesity will be covered only under these guidelines:

    The Plan Participant must be morbidly obese (defined as 100 pounds above normal body weight) with a history of Morbid Obesity for at least five (5) years;

    And have a documented history of participation in medically supervised weight loss programs for at least three (3) of the five (5) years the person has been Morbidly Obese;

    And must have participated in a medically supervised weight loss program with documented weekly attendance for at least twelve 12) months during the last year.

    And must have attended and complied with nutritional counseling and exercise programs under the guidance of their Primary Care Physician or Family Physician for the last twelve (12) consecutive months;

    And must be of an acceptable age and risk for surgery or medical treatment as determined by the Primary Care Physician or Family Physician;

    All treatments for Morbid Obesity must be managed through Case Management.

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

39. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs, and medicines, and first-aid supplies and nonhospital adjustable beds.

40. **Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this document.

41. **Private Duty Nursing**

42. **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother, or sister, whether the relationship is by blood or exists in law.

43. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

44. **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, Illness or Pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Medical Benefits Schedule or required by applicable law.

45. **Sclerotherapy.** Charges for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of lower extremities.

46. **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

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. **Sex Changes.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

49. **Sleep Disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

50. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.

51. **Tobacco Cessation.** Tobacco cessation care and treatment is excluded except to the extent (1) Medically Necessary due to a severe active lung Illness such as emphysema or asthma, or (2) required under standard Preventive Care.

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.

ARTICLE XIV
PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. See ID card for the administrator of the Pharmacy drug plan.

Prescription Drugs purchased from a participating Pharmacy when the Plan Participant's ID card is not used are **not covered.**

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, the mail order Pharmacy is able to offer Plan Participants significant savings on their prescriptions.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives unless otherwise specifically excluded, 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.

LIMITS TO THIS BENEFIT

This benefit applies only when a Plan Participant 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.

Drugs that are newly introduced to the U.S. market are subject to the Drug benefits exclusions. Drugs that are approved by the FDA for indications not specifically excluded are generally covered but may be subject to higher Copayments in drug formulary plans and tier-copayment plans. Generally, a new Drug approved for indications not specifically excluded is covered upon FDA approval but is subject to the higher Copayment tier until evaluated by the PBM, which may assign the Drug to a lower Copayment tier.

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. **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.

3. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

4. **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.

5. **Drugs Used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

6. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Plan Participant.

7. **FDA.** Any drug not approved by the Food and Drug Administration.

8. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

9. **Immunization.** Immunization agents or biological sera.

10. **Impotence.** A charge for impotence medication. Except, Medically necessary prescriptions, FDA approved, for the care and treatment of impotency/erectile dysfunction, and on the MagallenRX formulary

11. **Infertility Medication.** Used to treat Infertility.

12. **Injectable Supplies**: A charge for hypodermic syringes and /or needles (other than for insulin)

13. **Inpatient Medication.** A drug or medicine that is to be taken by the Plan Participant, 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. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

18. **No Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin or to over the counter drugs that are prescribed by a Physician as required for standard Preventive Care.

19. **Off-Label Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

20. **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

ARTICLE XV
CLAIMS PROCEDURES

When services are received from a health care Provider, a Plan Participant should show his or her **identification card** to the Provider.

If it is necessary for a Plan Participant to submit a Claim, he or she should request an itemized bill which includes procedure (CPT) and diagnostic (ICD) codes from his or her health care Provider.

To assist the Claims Administrator in processing the Claim, the following information must be provided when submitting the Claim for processing:

- A copy of the itemized bill
- Group name and number
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of Plan Participant
- Name, address, telephone number of the Provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a Claim form from the Claims Administrator. Claim forms are also available at

https://www.jpfarley.com/

WHERE TO SUBMIT CLAIMS

J.P. Farley Corporation is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

J.P. Farley Corporation
29055 Clemens Road
Westlake, Ohio 44145
(800) 634-0173

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion. The Plan also encourages Plan Participants to obtain second opinions as outlined in the Covered Charges section set forth above.

The Plan Administrator will only process Clean Claims as defined by this Plan Document.

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

TYPES OF CLAIMS

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an Authorized Representative of a Plan Participant that complies with the Plan's procedures for filing benefit Claims).

A Claimant may appoint an Authorized Representative to act upon his or her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an Authorized Representative will be considered an Authorized Representative. A healthcare Provider is not an Authorized Representative simply by virtue of an Assignment of Benefits; however, a healthcare Provider can represent the Claimant in Claims involving Urgent Care. Contact the Claims Administrator for information on the Plan's procedures for Authorized Representatives. There are four types of Claims:

A **Pre-Service Claim** is a reduction in benefits for certain Covered Services because the Plan Participant did not obtain the required Plan approval before receiving the care or treatment. This Plan does require prior approval for certain Covered Services or treatments as a condition to receiving benefits under the Plan. The review program is known as Precertification. See the Medical Benefits Schedule (Article III) and the Cost Management Services (Article IX) in this Plan for more information.

An **Urgent Care Claim** is any Pre-Service Claim where the application of the time periods for review and determination of the Pre-Service Claim could seriously jeopardize the life or health of the Plan Participant or the Plan Participant's ability to regain maximum function, or – in the opinion of the Plan Participant's treating Physician, would subject the Plan Participant to severe pain that cannot be managed without the proposed care or treatment.

A **Concurrent Care Determination** is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan Participant, Case Management is not considered a Concurrent Care Determination. Please refer to Article IX - Cost Management Services of this Plan.*

A **Post-Service Claim** is a Claim for medical care, treatment, or services that a Claimant has already received.

INITIAL BENEFIT DETERMINATION

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and Exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

The initial benefit determination will be made as follows:

Pre-Service Claims for Urgent Care. If the Pre-Service Claim is determined by the Claims Administrator to be a Claim involving Urgent Care, notice of the Plan's decision will be provided to the Plan Participant as soon as possible but no later than 72 hours after receipt of the Pre-Service Claim by the Claims Administrator.

The exception is if the Plan Participant does not provide sufficient information to decide the Pre-Service Claim. In that case, notice requesting specific additional information will be provided to the Plan Participant within 24 hours of receipt of the Pre-Service Claim.

The Plan's decision regarding the Pre-Service Claim will be made as soon as possible but no later than 48 hours after the earlier of:

- The Plan's receipt of the requested information or
- The expiration of the time period set by the Plan for the requested information (at least 48 hours).

Pre-Service Claims for non-Urgent Care. If the Pre-Service Claim is not an Urgent Care Claim, written notice of the Plan's decision will generally be provided to the Plan Participant within a reasonable period of time, but no later than 15 days after receipt of the Pre-Service Claim by the Claims Administrator.

If matters beyond the control of the Claims Administrator so require, one 15-day extension of time for processing the Pre-Service Claim beyond the initial 15 days may be taken. Written notice of the extension will be furnished to the Plan Participant before the end of the initial 15-day period. If an extension is required because the Plan Participant did not provide the information necessary to make a determination on the Claim, the notice of extension will specifically describe the required information.

The time-period for processing the Pre-Service Claim will be deferred beginning on the date this extension notice is sent to the Plan Participant and ending on the earlier of:

- The date the Plan receives a response to the request for additional information, or
- The date set by the Plan for a response (which will be at least 45 days).

Concurrent Care Determination. The initial benefit determination on a Concurrent Care Determination will be made within 15 days of the Claim Administrator's notice of a Concurrent Care Claim. If additional information is necessary to process the Concurrent Care Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant or the healthcare Provider must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a Concurrent Care Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's or healthcare Provider's response for additional information, or
- The date set by the Plan for the Claimant or healthcare Provider to respond (which will be at least 45 days).

A benefit determination on the Concurrent Care Claim will be made within 15 days of the Plan's receipt of the additional information.

Post-Service Claim. The initial benefit determination on a Post-Service Claim will be made within 30 days of the Claim Administrator's receipt of the Claim. If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination on a Post-Service Claim is suspended until the earlier of:

- The date the Plan receives the Claimant's additional information, or
- The date set by the Plan for the Claimant to respond (which will be at least 45 days)

A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

NOTICE OF DETERMINATION

1. The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:
2. Specific reason(s) for the denial.
3. Reference to the specific Plan provisions on which the denial was based.
4. Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
5. Description of the Plan's claims review procedures and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following a notice of the determination on final review.

6. 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.

If applicable:

1. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the notice of the determination and that a copy will be provided free of charge to the Claimant upon request).
2. If the notice of the determination is based on the Medical Necessity or Experimental or Investigational Exclusion or similar such Exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim, or a statement that such explanation will be provided free of charge, upon request.
3. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the notice of determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively or is a retroactive cancellation or discontinuance because of the Plan Participant's failure to timely pay required premiums.

CLAIMS REVIEW PROCEDURE - GENERAL

A Claimant may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for Pre-Service Claims for Urgent Care;
- The Plan offers a two-level internal review procedure for a Pre-Service Claim (non-Urgent Care), Concurrent Care Claim, and Post Service Claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by either an appropriate Plan fiduciary or the Claims Administrator on the Plan's behalf who was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records, and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon, or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, Drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the initial benefit determination.

INTERNAL APPEAL PROCEDURE

First Level of Internal Review. To appeal a denial of a Claim, the Claimant must submit in writing, a request for a review of the Claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the Claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

Claims Administrator
Attention: Appeals
J.P. Farley Corporation
29055 Clemens Road
Westlake, Ohio 44145

An appeal will not be deemed submitted until it is received by the Claims Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan Administrator's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the initial benefit determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic notice of determination to the Claimant within:

- 72 hours of the receipt of the appeal for an Urgent Care Claim;
- 15 days of the receipt of the appeal for a Pre-Service Claim or a Concurrent Care Claim; or
- 30 days of the receipt of the appeal for a Post Service Claim.

Second Level of Internal Review. If the Claimant does not agree with the Claims Administrator's determination from the First Level of Internal Review, the Claimant may submit a second level appeal in writing. The Claimant may request a second level appeal on Pre-service Claims (non-Urgent Care) and Post-Service only along with any additional supporting information.

The written request for review of the first level of internal review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

Claims Administrator
Attention: Appeals
J.P. Farley Corporation
29055 Clemens Road
Westlake, Ohio 44145

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The second level of internal review will be done by the Plan Administrator, or its designee. The Plan Administrator will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The

Plan Administrator will send a written or electronic Final Internal Adverse Benefit Determination for the second level of review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a Pre-Service Claim (non-Urgent Care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a Concurrent Care Determination;
- 30 days of the Plan's receipt of Claimant's second level appeal on a Post-Service Claim.

If the Claimant is not satisfied with the outcome of the final determination on the second level of internal review, the Claimant may be eligible for an External Review. The Claimant must exhaust both levels of the internal review procedure before requesting an external review. In certain circumstances, the Claimant may also request an expedited external review.

Both the First Level of Internal Review Decision and Second Level of Internal Review Decision will contain the following, if applicable:

1. Information sufficient to allow the Claimant to identify the Claim involved (including date of service, the health care Provider, the Claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial, 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, and a discussion of the decision.
3. A reference to the specific portion(s) of the Plan provisions on which the denial is based.
4. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request).
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
6. Any rule, guideline, protocol, or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request.
7. A description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
8. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
9. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Plan Participant's right to bring civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review.
10. In the case of denials based upon medical judgment (such as whether the treatment is Medically Necessary or Experimental), either 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 to the Claimant free of charge, upon request.

EXTERNAL REVIEW PROCEDURE

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the Final Internal Adverse Benefit Determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or services is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an external review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for external review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon the Plan and the Claimant, except to the extent other remedies may be available under applicable law.

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the notice of determination on the final level of internal or external review, whichever is applicable.

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.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Plan Participant may designate another individual to be an Authorized Representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit Claim or appeal of a denial. This authorization must be in writing, signed and dated by the Plan Participant, and include all the information required in the Authorized Representative form. The appropriate form can be obtained from the Plan Administrator or the Claims Administrator.

Should a Plan Participant designate an Authorized Representative, all future communications from the Plan will be conducted with the Authorized Representative instead of the Plan Participant, unless the Plan Administrator is otherwise notified in writing by the Plan Participant. A Plan Participant can revoke the Authorized Representative designation at any time. A Plan Participant may authorize only one person as an Authorized Representative at a time. Recognition as an Authorized Representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion of a similar form. An Assignment of Benefits by a Plan Participant shall not be recognized as a designation of the Provider as an Authorized Representative.

CONDITIONS AND LIMITATIONS OF AN ASSIGNMENT OF BENEFITS

The validity of an Assignment of Benefits by a Plan Participant to a Provider is limited by the terms of this Plan Document. An Assignment of Benefits is considered valid on the condition that the Provider accepts the payment received from the Plan as consideration, in full, for Covered Charges. This amount does not include any cost sharing amounts (i.e., Copayments, Deductibles, or Coinsurance), or charges for non-Covered Charges; the Provider may bill the Plan Participant directly for these amounts.

Notwithstanding the foregoing, the Plan Participant does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Plan Participant them self may be afforded under applicable law and the terms of the Plan. This includes, but is not limited to, any right to bring suit as such is afforded to Plan Participants under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a Provider is strictly prohibited.

An Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein. An Assignment of Benefits does not grant a Provider the right to pursue the administrative remedies available under this Plan. The administrative remedies are reserved for Plan Participants.

The Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Plan Participant as the sole recipient of the benefits available under the terms of the Plan.

An Assignment of Benefits by a Plan Participant to a Provider will not constitute the appointment of an Authorized Representative.

By submitting a Claim to the Plan and accepting payment by the Plan, the Provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan Document. The Provider further agrees that the payments received constitute an “accord and satisfaction” and consideration in full for the Covered Charges rendered. The Provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The Provider agrees to the specific condition that the Plan Participant may not be balance billed for any amount beyond applicable cost sharing amounts (i.e., Copayments, Deductible, or Coinsurance), or charges for non-Covered Charges; the Provider may bill the Plan Participant directly for these amounts.

If a Provider refuses to accept an Assignment of Benefits under the conditions and limitations as set forth herein, any benefits payable under the terms of the Plan Document will be payable directly to the Plan Participant and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Charges.

ARTICLE XVI
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 Plan Participant is covered by this Plan and another plan, or the Plan Participant'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 up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Plan Participant.

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.

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 Covered 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 Maximum 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. This includes situations in which a person who is covered as a Dependent child under one benefit plan is also covered as a Dependent Spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of the Maximum 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 Plan 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 Plan Participant will give this Plan the information it asks for about other plans and their payment of Covered 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 Plan Participant. 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 Maximum 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 Plan Participant under the Plan.

Applicable to Active Employees and Spouses Ages 65 and Over. An active Employee and his or her Spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Plan Participants Eligible for Medicare Benefits. To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Plan Participants Who Are Covered Under This Plan. If any Plan Participant is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

ARTICLE XVIII
THIRD PARTY RECOVERY, SUBROGATION, AND REIMBURSEMENT PROVISION

Payment Condition. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to the terms and conditions set forth herein. In those situations where an Injury, Illness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage"), the Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations.

Plan Participant(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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

Subrogation. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all Claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

If the Plan Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Plan Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Plan Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Plan Participant's/Plan Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s). This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease, or disability.

Plan Participant is a Trustee Over Plan Assets. Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Plan Participant understands that he or she is required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.

2. Instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.

3. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment, or other source of Coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or Authorized Representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Plan Participant, beneficiary, or the agents or Authorized Representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability. The Plan's right to reimbursement extends to any incident related care that is received by the Plan Participant(s) (Incurred) prior to the liable party being released from liability. The Plan Participant's/Plan Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the Claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Plan Participant has an obligation to review the "lien" provided by the Plan and reflecting Claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

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

Reimbursement Due to Surrogacy Arrangement. If a Plan Participant enters into a Surrogacy Arrangement, the Plan Participant must reimburse the Plan for Covered Charges received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Plan Participant or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Plan Participant agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the Plan Participant receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Plan Participant's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Plan Participant surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

As set forth above, as a condition precedent to the Plan Participant receiving benefits under the Plan, the Plan Participant

automatically assigns to the Plan any right to receive payments that are payable to the Plan Participant or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Plan Participant must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses and telephone numbers of all parties to the arrangement;
2. Names, addresses and telephone numbers of any escrow or trustee;
3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;
4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to:

Plan Administrator
Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

The Plan Participant must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Plan Participant may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Plan Participant's estate, parent, guardian, or conservator asserts a Claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Plan Participant had asserted the Claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

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

Obligations. It is the Plan Participant's/Plan Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Illness, Disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

5. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received.
6. To notify the Plan or its Authorized Representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan Participant may have against any responsible party or Coverage.
9. To instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on any settlement draft.
10. In circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its Authorized Representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's/Plan Participants' cooperation or adherence to these terms.

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

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

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

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

Severability. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ARTICLE XVIII
CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Port Health Services Group Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended, and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. The COBRA Administrator is J.P. Farley Corporation. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept Late Enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

2. Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the Employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a

Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee.

2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

4. A covered Employee's enrollment in any part of the Medicare program.

5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This 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. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. You may want to check to see if your current health care Providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the Employer, the former Employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at (866) 444-3272 to discuss options.

- **Medicare Eligibility:** You should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after your employment - related health coverage ends. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plan.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay Copayments, Deductibles, Coinsurance, or other amounts as benefits are used. Qualified beneficiaries should 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.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. The end of employment or reduction of hours of employment,

2. Death of the Employee,

3. Commencement of a proceeding in bankruptcy with respect to the Employer, or

4. Entitlement of the Employee to any part of Medicare.

IMPORTANT:

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 or someone on your behalf must notify the Plan Administrator at 29055 Clemens Rd., Westlake, Ohio, 44145, (800) 634-0173. within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person listed at the address shown above.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period.

2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.

4. The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

5. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

    b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent Claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

3. In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

4. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36

months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to **Plan Administrator at 29055 Clemens Rd., Westlake, Ohio, 44145, (800) 634-0173** in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to **Plan Administrator at 29055 Clemens Rd., Westlake, Ohio, 44145, (800) 634-0173** in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact **Plan Administrator at 29055 Clemens Rd., Westlake, Ohio, 44145, (800) 634-0173**. 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 Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

ARTICLE XIX
RESPONSIBILITIES FOR PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall establish the policies, practices, and procedures of this Plan. The Plan Administrator shall administer this Plan in accordance with its terms. 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 (including the determination of what services, supplies, care and treatments are Experimental), 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 as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator, in its discretion, that the Plan Participant is entitled to them.

DUTIES OF THE PLAN ADMINISTRATOR.

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

2. To determine all questions of eligibility, status, and coverage under the Plan.

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms.

4. To make factual findings.

5. To decide disputes which may arise relative to a Plan Participant's rights.

6. To prescribe procedures for filing a Claim for benefits, to review Claim denials and appeals relating to them and to uphold or reverse such denials.

7. To keep and maintain the Plan Documents and all other records pertaining to the Plan.

8. To appoint and supervise a Claims Administrator to pay Claims.

9. To perform all necessary reporting as required by ERISA.

10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;

11. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan’s administration.

Plan Administrator 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.

ARTICLE XX
FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee Coverage: Funding is derived from contributions made to the Port Health Services Group Health Plan by the covered Employees and Employer contributions.

For Dependent Coverage: Funding is derived from contributions made by the covered Employees.

The level of any Employee contributions will be set by the Employer. 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 Plan Sponsor or Plan Administrator 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).

DISTRIBUTION OF ASSETS

Subject to the requirements of ERISA §402, in the event of a termination or partial termination of the Plan or Trust (if applicable), Port Health Services shall direct the disposition of Plan assets pursuant to applicable law and governing documents, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by an Employer.

ARTICLE XXI
HIPAA PRIVACY AND SECURITY

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

DISCLOSURE OF SUMMARY HEALTH INFORMATION TO THE PLAN SPONSOR

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending, or terminating the Plan.

Summary Health Information may be individually identifiable health information and it summarizes the Claims history, Claims expenses or the type of Claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO THE PLAN SPONSOR FOR PLAN ADMINISTRATION PURPOSES

Protected Health Information (PHI) means individually identifiable health information, created, or received by a health care Provider, health plan, Employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

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

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the

return or destruction of the PHI infeasible; and

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)) is established as follows:

a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

- HR Manager

b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

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

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, Claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

DISCLOSURE OF CERTAIN ENROLLMENT INFORMATION TO THE PLAN SPONSOR

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

DISCLOSURE OF PHI TO OBTAIN STOP-LOSS OR EXCESS LOSS COVERAGE

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit Claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

OTHER DISCLOSURES AND USES OF PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

CONTACT INFORMATION

Privacy Officer Contact Information:
HR Manager
Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (THE "PRIVACY STANDARDS") ISSUED PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware.

ARTICLE XXII
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.

If a Plan Participant's Claim for a benefit is denied or ignored, in whole or in part, the Plan 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 Plan 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/agencies/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ARTICLE XXIII
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan, and the administration is provided through a 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

Port Health Port Health Services Group Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 20-0287545

PLAN EFFECTIVE DATE: 11/01/2021

PLAN YEAR: November 1 – October 31

EMPLOYER INFORMATION

Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

PLAN ADMINISTRATOR

Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

NAMED FIDUCIARY

Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

AGENT FOR SERVICE OF LEGAL PROCESS

Port Health Services
4300-110 Sapphire Ct.
Greenville, NC 27834
(252)830-7540

CLAIMS ADMINISTRATOR

J.P. Farley Corporation
29055 Clemens Rd
Westlake, Ohio 44145
(800) 634-0173

I,_____, certify that I am the _____
Name Title

of Port Health Services, the above named Plan has an initial effective date of 11/01/2021, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms stated herein and am hereby authorizing the implementation of the Plan as of the effective date stated above.

Signature: _____

Print Name: _____

Date: _____