CITY OF JACKSONVILLE
UF HEALTH DIRECT CARE
EMPLOYEE HEALTH AND WELFARE PLAN

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PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Effective: January 1, 2018

Restated: January 1, 2022

Corrected April 28, 2022

Third Party Administrator:
INTEGRA Administrative Group, Inc.
110 S. Shipley Street
Seaford, DE 19973

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ESTABLISHMENT OF THE *PLAN*

THIS *PLAN DOCUMENT* AND *SUMMARY PLAN DESCRIPTION* (the "*summary plan description*"), made by City of Jacksonville (the "*City*" or the "*Plan Sponsor*") restated as of January 1, 2022, hereby sets forth the provisions of the City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan (the "*Plan*"). which was originally adopted by the *Company*, effective January 1, 2018.

Effective date of the *Plan*
The *summary plan description* is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the summary plan description
The *Plan Sponsor*, as the settlor of the *Plan*, hereby adopts this *summary plan description* as the written description of the *Plan*. This *summary plan description* represents both the *plan document* and the *summary plan description*, which is required by applicable law. This *summary plan description* amends and replaces any prior statement of the health care coverage contained in the *Plan* or any predecessor to the *Plan*.

IN WITNESS WHEREOF, the Plan Sponsor has caused this summary plan description to be executed.

City of Jacksonville

By: Mary DiPerna

Name: Mary DiPerna

Date: 04/29/2022 Title: Chief, Compensation and Benefits

LANGUAGE ASSISTANCE SERVICES

Spanish
ATENCIÓN: si habl!a español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

French Creole (Haitian Creole)
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-904-630-1212 Ext. 5331 (TTY：1-904-630-4933）。

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-904-630-1212 Ext. 5331 (ATS : 1-904-630-4933).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-904-630-1212 Ext. 5331 (телетайп: 1-904-630-4933).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-904-630-1212 Ext. 5331 (رقم هاتف الصم والبكم: 1-904-630-4933).

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933)번으로 전화해 주십시오.

Polish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-904-630-1212 Ext. 5331 (TTY: 1-904-630-4933).

GENERAL *PLAN* INFORMATION

What is the purpose of the *Plan*?
The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The *Plan* is not a contract of employment between you and your *participating employer* and does not give you the right to be retained in the service of your *participating employer*.

The *City* reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the *Plan* at any time, for any reason, and without prior notice. Benefits under this *Plan* are not vested. Neither you, your *spouse*, your *dependents*, your beneficiaries nor any other person have or will have a vested or nonforfeitable right to receive benefits under the *Plan*.

The purpose of this *summary plan description* is to set forth the terms and provisions of the *Plan* that provide for the payment or reimbursement of all or a portion of certain medical expenses. The *summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *participant*.

General Plan Information You Should Know

Name of *Plan*:	**City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan**
***Plan Sponsor*/ *Administrator*:**	**City of Jacksonville 117 West Duval Street, Suite 150 Jacksonville, Florida 32202 904-630-1314**
***Plan Sponsor* ID No. (EIN):**	**59-6000344**
***Plan Year*:**	**January 1 through December 31**
***Plan* Type:**	**Medical Prescription Drug**
***Plan* Funding:**	**Self-funded**
Third Party Administrator:	**INTEGRA Administrative Group, Inc. 110 S. Shipley Street Seaford, DE 19973 302-629-3518**
Source of Contributions:	**Employee and Employer**
Source of Benefits:	**Assets of the Employer**

Participating Employer(s):	**City of Jacksonville; Jacksonville Housing Authority; Northeast Florida Regional Council; and First Coast Workforce Development Consortium.**
Agent for Service of Process:	**City of Jacksonville** **Mary DiPerna, MAcc, CEBS, Chief of Compensation & Benefits** **117 West Duval Street, Suite 150** **Jacksonville, Florida 32202** **904-630-1314**

The *Plan* shall take effect for each *participating employer* on the *effective date* shown on the cover, unless a different date is set forth above.

The *Plan* is a legal entity. Legal notice may be filed with, and legal process served upon, the *Plan Administrator*.

ELIGIBILITY FOR PARTICIPATION

Employee eligibility requirements
As a full-time *employee* regularly scheduled to work at least 30 hours per week or 130 hours of service in a calendar month, and as a qualified part-time *employee* (as defined below), you are eligible for coverage on the first day of the month following your date of hire. If your employment date is the first day of the month, you are eligible for coverage on your date of hire.

A qualified part-time *employee* is a part-time *employee* of a *participating employer* who:

- Is represented by Bargaining Unit 179 of the America Federation of State, County and Municipal Employees, AFL-CIO (AFSCME);
- Works in one of the following job categories: OP7CL, OP7SM, OP7TS, 3T7TS, OW7CL, 3P7CB or 3T7CB; and
- Is covered by a collective bargaining agreement that provides for participation in the Plan.

As an employee in the Office of General Counsel, you are eligible for coverage on the first day of the month following date of hire.

As a retired *employee* of the *employer* who meets the definition of an eligible retiree. An eligible retiree is a former employee who has ended his or service to the *City* (or another *participating employer*) and is eligible, by IRS tax rules or related City Code, to receive, or has begun receiving, a retirement allowance and/or other benefits from the *City's* retirement system. Contact your *Plan Administrator* if you would like more information on the conditions for becoming an eligible retiree.

As a *variable employee*, you may be eligible for coverage when there has been a determination through calculation of a *standard measurement period* showing that you have completed an average of 30 hours of service per week, or more during this *standard measurement period*.

As a *variable employee*, you may be eligible for coverage on the day following your *initial measurement period* or your *standard administrative period*. Your eligibility will be determined through an average hour calculation showing that you have averaged a minimum of 30 hours of service per week during your *initial measurement period* and/or your *standard measurement period* when there has been a determination through calculation of a *standard measurement period* showing that you have completed an average of 30 hours of service per week or more during this *standard measurement period*.

You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the first of the month following your first day of work.

Independent contractors, leased employees, and any other individuals who are not reported on the payroll records of a *participating employer* as common law employees will not be eligible to participate in the *Plan*. Such individuals are excluded from *Plan* participation even if a court or administrative agency determines that such individuals are common law employees of a *participating employer*.

Employees covered by a collective bargaining agreement are not eligible to participate in the *Plan* unless such collective bargaining agreement provides for participation in the *Plan*.

Dependent eligibility requirements
Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;

- The date coverage for *dependents* first becomes available under the *Plan*; and
- The first date upon which you acquire a *dependent*.

Please note: You must be covered under the *Plan* in order to cover any *dependents*.

Your *dependents* must live in the United States to be eligible for coverage.

No *dependent child* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent.*

Effective date
Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 60 days following the date of eligibility.
- For a *dependent child who* is born after the date your coverage becomes effective:
- You must make written application and agree to any required contribution **during the first 60-day period from birth**. Coverage for the *dependent* child will then become effective from the moment of birth.
- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required contributions, within 60 days of the date of eligibility.

Open Enrollment Periods
You may enroll during the *Plan's* open enrollment period as specified below.

- You and your *dependents* may enroll for coverage during the *Plan's* annual open enrollment period, as determined by the *employer* each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on January 1, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the first day of the month following your completion of the *waiting period*.
- If you and your *dependents* are currently enrolled with the *Plan* and would like to change your *Plan* benefit coverage, you may do so during the *Plan's* annual open enrollment period, as determined by the *employer* each *plan year*. Any *waiting period* satisfied will be credited.
- If no election change is made during open enrollment, the *employee* will automatically retain his or her present coverage.

Exceptions for enrollment

Special Enrollment Periods
This *Plan* provides special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period.

Changing Coverage Once Enrolled
If your coverage begins on the first day of the month, you have 60 days to make changes to your election. If you decide to make a change, that change will be effective the next payroll period.

Loss of Other Coverage
If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 60 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on November 14.

Changes in Coverage of Dependents Under Other Plans
You may also change your elections to correspond to certain changes made under another employee benefit plan. For example, if your ***spouse's*** employer has a cafeteria plan with an election period that is different from this *Plan's* open enrollment period, you may change your benefit elections to correspond to the changes elected by your *spouse* during his or her employer's annual election period. Also, if another employer sponsors a cafeteria plan that allows participants to make changes during a plan year, such as the ones permitted by this *Plan*, and a permitted change under that other plan affects you or your eligible *dependent*, you may elect changes to your coverage under this *Plan*, as long as your change corresponds with the change made under that other plan. Election changes are subject to the eligibility requirements as specifically stated in the Dependent eligibility requirements section.

The following conditions apply to any eligible *employee* and d*ependents:*

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan;*
- You are not currently enrolled under the *Plan*;
- When enrollment was previously offered, you declined because of coverage under another group health plan or health insurance coverage. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan;* and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An *employee* who is already enrolled in a benefit package may enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage. You must make written application for special enrollment in the new benefit package within 60 days of the date the other health coverage was lost.

You are not eligible for this special enrollment right if:

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the date of the special enrollment.

***Dependent* requirement(s)**
Dependent means one or more of the following person(s):

- An e*mployee*'s lawfully married spouse possessing a marriage license who is not divorced from the e*mployee.* For purposes of this section, "*spouse*" means an individual who is legally married to a *participant*, including same-sex marriage. The *Plan* does not recognize common law marriages, regardless of whether the marriage is recognized in any state.

- An e*mployee*'s *child* who is less than 26 years of age.

- An *employee*'s *child* who is age 26 or older through the end of the year in which he or she turns 30 years old; provided, however, that such *child* must satisfy the following eligibility criteria:
    - He/she is unmarried; and
    - He/she has no dependents of his/her own (i.e. children); and
    - He/she is dependent on an employee for financial support; and
    - He/she is not provided coverage or covered under any other group or individual benefit plan; and
    - He/she is not entitled to benefits under Title XVIII of the Social Security Act; and
    - He/she is a resident of Florida or is a full or part-time student.

- An unmarried enrolled dependent child age 26 or over who is:
    - Incapable of self-sustaining employment because of an intellectual or physical disability; and
    - Chiefly dependent upon you for support and maintenance.

- A newborn *child* of a *covered dependent child*. Such *child* will be eligible for coverage for 18 months from the date of birth as long as:
    - The baby is born while the *covered dependent child* is covered under the *Plan*, and
    - The *covered dependent child* remains covered under the *Plan*, and
    - The *employee* requests enrollment of the newborn on the *Plan* within 60 days of the date of birth.

  At the end of the 18 month period, coverage for the newborn will be terminated and will not be eligible for conversion.

"Child(ren)" means, in addition to the *employee's* own blood descendant of the first degree or lawfully adopted child, a child placed with the *employee* in anticipation of adoption, a foster child, a child who is an *alternate recipient* under a "qualified medical child support order" (QMCSO) as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other child for whom the *employee* has obtained legal guardianship, court-ordered temporary or other custody, or a newborn *child* of a covered *dependent child*.

"*Dependent*" does not include the following: other individuals living in the covered *employee's* home, but who are not eligible as defined; the legally separated or divorced former spouse of the *employee*; a "civil union" partner; a domestic partner; any person who is on active duty in any military service of any country; or any person who is covered under the *Plan* as an *employee*.

The *Plan* reserves the right to require documentation, satisfactory to the *Plan Administrator*, which establishes a *dependent* relationship.

Surviving Dependents of a *Deceased* Retiree
The following surviving *dependents* who were receiving health insurance coverage at the time of the insured retiree's death are eligible to continuing receiving such coverage after the death of the retiree:

- The surviving *spouse* of a deceased insured retiree.
- A surviving *child* of the deceased insured retiree until the *child* reaches age 26.

New Dependent
If you acquire a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must make written application for special enrollment no later than 60 days after you acquire the new *dependent*. For example, if you are married on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on November 14.

The following conditions apply to any eligible *employee* and *dependents:*

You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:

- You are eligible for coverage under the terms of this *Plan*, and
- You have acquired a new *dependent* through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective:

- For a marriage, the next pay period after the *employee* submits the appropriate documentation to Employee Benefits to elect enrollment for the spouse or dependent, but in no event later than the first day of the first calendar month beginning after the date the *Plan* receives the request for special enrollment.
- For a birth, on the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

Additional Special Enrollment Rights
Employees and *dependents* who are eligible but not enrolled are entitled to enroll under the following circumstances:

- The *employee's* or *dependent's* Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the *employee* requests coverage under the *Plan* within 60 days after the termination; or

- The *employee* or *dependent* becomes eligible for a premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the *employee* requests coverage under the *Plan* within 60 days after eligibility is determined.

Notice of HIPAA Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after you or your dependents' coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You also may have special enrollment rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). These rights occur when an employee or dependent child

- loses eligibility for coverage under Medicaid or a State Children's Health Insurance Program (acronym "CHIP," for children whose families do not qualify for Medicaid); or
- becomes eligible for premium assistance from Medicaid or CHIP allowing him or her to enroll in a group health plan.

However, you must request enrollment within 60 days after the date of coverage loss or eligibility for Medicaid or CHIP premium assistance, whichever applies.

To request special enrollment or obtain more information, contact the City's Employee Benefits Department.

When spouses are also covered employees
When both you and your spouse are covered *employees*, and you have family coverage for *dependent children*, the *Plan* will allow one spouse to be treated as a *dependent* for purposes of calculating the *family unit deductible* and *out-of-pocket expense* amount. This will allow for the full benefit of family coverage and reduce the *out-of-pocket expenses* for the *family unit*.

Changing between employee and dependent status
When you change your coverage status between that of an *employee* and a *dependent*, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current *plan year deductible* and *out-of-pocket expense* limit, and any amounts applied toward *Plan* maximums will be carried forward.

Changing Your Coverage
You may make coverage changes during the year if you experience a change in status. The change in coverage must be consistent with the change in status (e.g., you cover your spouse following your marriage, your child following an adoption, etc.). The following are considered status changes for purposes of the Plan:

- Events that change your legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment.
- Events that change your number of dependents, including birth, adoption, placement for adoption, or death of a dependent.
- Any of the following events that change your employment status, or the employment status of your spouse or your dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of your employer, your spouse's employer, or your dependent's employer depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance.
- A change in your place of residence, or the place of residence of your spouse or dependent, that would lead to a change in status (such as a loss of HMO coverage).

- An election that corresponds with the special enrollment rights provided in Internal Revenue Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (SCHIP); provided that you meet the sixty (60) day notice requirement imposed by Internal Revenue Code Section 9801(f). Such change shall take place on a prospective basis, unless otherwise required by Internal Revenue Code Section 9801(f) to be retroactive.
- You, your spouse, or your dependent become entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If you, your spouse, or your dependent who has been entitled to Medicaid or Medicare coverage lose eligibility, that individual may prospectively elect coverage under the Plan if a benefit package option under the Plan provides similar coverage.
- If the cost you pay for benefits under the Plan increases significantly, you will be permitted to either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage (if applicable), or drop coverage prospectively if there is no benefit package option with similar coverage.
- If the coverage under the Plan is significantly curtailed or ceases during a Plan Year, you may revoke your elections and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage (if applicable), or drop coverage prospectively if no similar coverage is offered.
- If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.
- You may make a prospective election change to add coverage under the Plan for yourself, your spouse, or your dependent, if such individual loses group health coverage sponsored by a governmental or educational institution, including a state children's health insurance program under the Social Security Act, the Indian Health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.
- Any other change in status permitted pursuant to regulations promulgated by the Secretary of the Treasury.

Furthermore, you may prospectively revoke coverage under the Plan provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

- You have been reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in you ceasing to be eligible under the Plan; and
- The revocation of coverage under the Plan corresponds to your intended enrollment (and the enrollment of any related individuals who cease coverage due to the revocation) in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Plan Administrator may rely on your reasonable representation that you and the related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new

coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

Conditions for revocation due to enrollment in a Qualified Health Plan:

- You are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace (federal or state exchange) pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and

- The revocation of the election of coverage under the Plan corresponds to your intended enrollment (and the enrollment of any related individuals who cease coverage due to the revocation) in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

The Plan Administrator may rely on your reasonable representation that you and the related individuals have enrolled or intend to enroll in a Qualified Health Plan for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Unless otherwise noted above, if you wish to change your elections, you must contact the City's Employee Benefits Department within 60 calendar days of the change in status. Otherwise, you will need to wait until the next Annual Enrollment.

TERMINATION OF COVERAGE

Termination of *employee* coverage
Your participation will terminate on the earliest of the following dates:

- If your termination date is the first of the month through the 15th, your benefits will end at midnight on the 15th;
- If your termination date is the 16th of the month through the 30th or 31st, your benefits will end at midnight of the 30th or 31st;
- The date the *Plan* terminates;
- The last day of the month the *third party administrator* receives written notice from the *City* to end your coverage, or the date requested in the notice, if later;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The last day of the month on which you cease to be eligible for coverage under the *Plan*;
- The last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage;
- The date following the end of the *stability period* for *variable employees;*
- The end of the *stability period* if you failed to qualify during the previous stand*ard measurement period*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for my *dependents*?
The coverage for your *dependents* will terminate on the earliest of the following dates:

- The date your coverage ends;
- The last day of the month the *third party administrator* receives written notice from the *City* to end your coverage, or the date requested in the notice, if later;
- The date the *Plan* terminates;
- The last day of the month the *Plan* discontinues coverage for *dependents*;
- The date your *dependent* becomes covered as an *employee* under this *Plan*;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your *dependents*;
- In the case of *child* age 26 or older for whom coverage is being continued other than for reasons of mental or physical disability, the earliest of:
    - The beginning of the year following the year in which the *child* turned age 30;

  - The date the *child* marries;
  - The date the *child* acquires a dependent;
  - The date the *child* is no longer dependent upon you for financial support;
  - The date the *child* is provided coverage under any other group or individual benefit plan;
  - The date the *child* becomes eligible for benefits under Title XVIII of the Social Security Act; or
  - The date the *child* ceases to be a resident of Florida or a full or part-time student.

- In the case of an unmarried *child* age 26 or older for whom coverage is being continued due to his or her inability to maintain self-sustaining employment because of a mental or physical disability, the earliest of:
  - Cessation of the inability;
  - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
  - Upon the *child*'s no longer being *dependent* on you for his or her support;
- The last day of the month on which person ceases to be a *dependent*; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

Certificate of Coverage
The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan*. In addition, a *certificate of coverage* will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

Family and Medical Leave Act (FMLA)
Notwithstanding any other provision of the *Plan*, if you take an approved leave of absence under the *FMLA*, coverage under the *Plan* will continue to be made available during such leave period to you and your covered *dependents* under the same terms and conditions that coverage was made available immediately prior to the commencement of the leave. If you do not wish to continue these benefits during the *FMLA leave*, you must inform the *City's* Employee Benefits Department before the start of the leave.

If you elect to continue your coverage during such a leave period, you must continue to pay any required employee-portion of the cost of the level of coverage elected. If any portion of the leave period is paid leave, the employee-portion of the cost of coverage will continue to be deducted from your pay on a pre-tax basis in accordance with your election. Upon returning from an approved *FMLA leave*, coverage under the *Plan* will immediately resume regardless of whether you elected to continue coverage during the *FMLA leave*.

City Contributions

While you are on an *FMLA leave*, the *City* will continue to make the same contributions toward the cost of coverage continued under the *Plan* that it would have made had you not taken such leave of absence. The *City* will continue to do so until the earlier of the date that (a) you fail to return to work on the expiration of the *FMLA leave*, or (b) you voluntarily give notice of your intent to terminate employment. For these purposes, you are considered to "terminate employment" when you give oral or written notice of your intent not to return to work due to reasons within your control.

If you voluntarily terminate your employment due to reasons within your control at or before the end of the *FMLA leave*, the *City* shall have the right to be reimbursed by you for any and all contributions the *City* has made on behalf of you and your covered *dependents* during the leave. In this regard, the *City* shall have the right to obtain reimbursement from any funds that the *City* might otherwise owe you following the voluntary termination, including (but not limited to) (a) any regular or overtime wages, commissions, salary, or bonuses; (b) accrued paid time off ("PTO"); or (c) other sources in accordance with state law. In addition, the *City* shall have the right to pursue reimbursement in a court of law. Regardless of whether or not you return from an *FMLA leave*, the *City* shall be entitled to recover from you any required employee contributions the *City* has made on behalf of you and your covered *dependents* during the unpaid leave to ensure continuity of coverage.

The *City* may not recover any of its regular contributions made on behalf of you and your covered *dependents* for the time you had been on an *FMLA leave* if your failure to return to employment at the expiration or exhaustion of such leave is due to (a) the continuation, recurrence, or onset of a serious health condition that would entitle you to the *FMLA leave*; or (b) other circumstances beyond your control (as set forth in the *City*'s policies and procedures).

Covered Employee Options

As soon as administratively feasible after you qualify for an *FMLA leave*, the *Plan Administrator* shall give you the opportunity to choose in writing between continued coverage during the leave of absence, or suspending coverage for the leave's duration. If you choose ongoing coverage, you must continue to make the same premium payments or contributions that you were making immediately before the leave took effect, as described above.

The *City* will send invoices for your share of the cost of coverage. You must pay premiums within the time period provided in the invoice, and any applicable grace period, or your coverage may be terminated, and you will not be able to re-enroll until the next open enrollment period.

The obligation to provide ongoing coverage under this *Plan* for you and your covered *dependents* on an *FMLA leave*, if any, ceases if you are more than thirty (30) days late on making a required premium payment; provided, however, that the *City* may—at its option—cover your missed payments so that coverage will be uninterrupted. In this event, the *City*'s advances may be recovered in the event you voluntarily terminate your employment under circumstances within your control.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

An *employee* who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue *Plan* coverage for the *employee* and the *employee*'s *dependents* in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (*USERRA*).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the *USERRA*, an *employee* may elect to continue coverage under the *Plan* by notifying the *Plan Administrator* in advance, and providing payment of any required

contribution for the health coverage. This may include the amount the *Plan Administrator* normally pays on an *employee*'s behalf. If an *employee*'s Military Service is for a period of time less than 31 days, the *employee* may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An *employee* may continue coverage under *USERRA* for up to the lesser of:

- The 24 month period beginning on the date of the *employee*'s absence from work; or
- The day after the date on which the *employee* fails to apply for, or return to, a position of employment.

Regardless of whether an *employee* continues health coverage, if the *employee* returns to a position of employment, the *employee*'s health coverage and that of the *employee*'s eligible *dependents* will be reinstated under the *Plan*. No exclusions or waiting period may be imposed on an *employee* or the *employee*'s eligible *dependents* in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the *Plan Administrator* if you have questions about your rights to continue health coverage under USERRA.

***Employee* reinstatement**
A terminated *employee* who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, except as stated in the Affordable Care Act (ACA) Measurement Method. However, if the *employee* is returning to work directly from *COBRA* coverage, this *employee* does not have to satisfy any employment *waiting period*.

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Preferred provider
A *preferred provider* is a *physician, hospital* or ancillary service provider which has an agreement in effect with the *Preferred Provider Organization (PPO)* to accept a reduced rate for services rendered to *participants*. This is known as the negotiated rate. The preferred provider cannot bill the participant for any amount in excess of the negotiated rate.

A current list of *preferred providers* is available, without charge, through a link located on the following website: www.integratpa.com. You may also contact your *preferred network* at the website on your *Plan* ID card*.

*The *Preferred Provider Organization* (PPO) is UF Health Direct Care Network.

Nonpreferred provider
A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. **This Plan does not cover expenses for nonpreferred provider services, except for services listed below.**

Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a non-*network provider* for any *covered service* is higher than the *maximum allowable charge* determined by the *Plan*, *participants* are responsible for the excess unless the *provider* accepts assignment of benefits as consideration in full for services rendered. Since *network providers* have agreed to accept a negotiated discounted fee as full payment for their services, *participants* are not responsible for any billed amount that exceeds that fee. The *Plan Administrator* reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any *provider*, at its discretion.

To receive benefit consideration, *participants* may need to submit claims for services provided by non-*network providers* to the *Third Party Administrator*. *Network providers* have agreed to bill the *Plan* directly, so that *participants* do not have to submit claims themselves.

Exceptions
Services rendered by nonpreferred *providers* are reimbursed at the *preferred provider* percentage payable for *usual, customary and reasonable fees* for the following exceptions*:

- Services which are covered by this *Plan* and are **not available** within the *preferred* network service area** through a *preferred provider.*
- Initial consultation/ office visit services provided by a nonpreferred *provider*, in which the *participant* has a medical emergency requiring immediate care.
- Services for participants, including but not limited to college students, that reside outside the preferred network service area**.
- If a *participant* receives information with respect to an item or service from the *Plan*, its representative, or a database maintained by the *Plan* or its representative indicating that a particular *provider* is a *network provider* and the *participant* receives such item or service in reliance on that information, the ***participant's*** coinsurance, copayment, *deductible*, and *out-of-pocket maximum* will be calculated as if the *provider* had been in the *network* despite that information proving inaccurate.

*The Plan will pay its percentage of the reasonable and customary amount for the nonpreferred provider services, supplies and treatment. **The *participant* is responsible for the remaining balance.**

****The Preferred Network Service Area is defined as Duval County, Florida, and the contiguous counties: Alachua, Baker, Clay, Nassau, and St. Johns.**

Florida law prohibits nonpreferred providers from balance billing you for differences between the providers' billed charges and the amount the *Plan* will pay for as described herein for (1) emergency health services provided by a nonpreferred provider; and (2) non-emergency services provided by a nonpreferred provider at a preferred facility when you did not have an opportunity to select a preferred provider (e.g. radiologist, anesthesiologist, pathologist and emergency room physician). You are still responsible for payment of all applicable copayments, coinsurance, and deductibles.

Continuity of Care
In the event a *participant* is a continuing care patient receiving a course of treatment from a *provider* which is in the *network* or otherwise has a contractual relationship with the *Plan* governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the *provider's* failure to meet applicable quality standards or for fraud, the *participant* shall have the following rights to continuation of care.

When the *Plan* has been notified by the *network* of a *provider's* terminated contractual relationship with the *network*, or after the termination of a *provider's* contractual relationship with the *Plan*, the *Plan* shall notify the *participant* in a timely manner of the *provider* termination and that the *participant* has rights to elect continued transitional care from the *provider.* If the *participant* elects in writing to receive continued transitional care, *Plan* benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the *Plan's* notice of termination is provided and ending 90 days later or when the *participant* ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

- Is undergoing a course of treatment for a serious and complex condition from a specific *provider*;
- Is undergoing a course of institutional or *inpatient* care from a specific *provider*;
- Is scheduled to undergo non-elective *surgery* from a specific *provider*, including receipt of postoperative care with respect to the *surgery*;
- Is *pregnant* and undergoing a course of treatment for the *pregnancy* from a specific *provider;* or
- Is or was determined to be terminally ill and is receiving treatment for such *illness* from a specific *provider*.

Note that during continuation, although *Plan* benefits will be processed as if the termination had not occurred and the law requires the *provider* to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the *Plan* may be unable to protect the *participant* if the *provider* pursues a balance bill.

No Surprises Act – *Emergency* Services and Surprise Bills
For non-*network* claims subject to the No Surprises Act ("NSA"), *participant* cost-sharing will be the same amount as would be applied if the claim was provided by a *network provider* and will be calculated as if the *Plan's allowable expense* was the *recognized amount*, regardless of the *Plan's* actual *maximum allowable charge*. The NSA prohibits *providers* from pursuing *participants* for the difference between the *maximum allowable charge* and the *provider's* billed charge for applicable services, with the exception of valid *Plan*-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward the *network deductibles* and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the *provider*.

Claims subject to the NSA are those which are submitted for:

- *Emergency* Services;
- Non-*emergency* services rendered by a non-*network provider* at a *participating health care facility*, provided the *participant* has not validly waived the applicability of the NSA; and
- Covered non-*network* air ambulance services.

Patient Protection Notice
Each *participant* has a free choice of any *provider*, and the *participant*, together with his or her provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The *preferred providers* are independent contractors; neither the *Plan* nor the *Plan Administrator* makes any warranty as to the quality of care that may be rendered by any *preferred provider*.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan,* including *deductibles, copayments* and the *coinsurance* percentage that is not paid by the *Plan.* This is called *"out-of-pocket expense."*

Deductibles
Deductibles and *copayments* are shown in the "Schedule of Medical Benefits." The *Plan* limits the amount of *deductible* expense you must pay for your *family unit*, as shown in the "Schedule of Medical Benefits."

Coinsurance
The *Plan* pays the percentage listed on the following pages for *covered expenses incurred* by a *participant* during a *plan year* after the individual or family deductible has been satisfied and until the individual or family medical *out-of-pocket expense* limit has been reached. These payment levels are also shown in the "Schedule of Medical Benefits."

Medical out-of-pocket
The *Plan* contains a limit for the amount of medical *out-of-pocket expense* you must pay toward *covered expenses,* shown in the "Schedule of Medical Benefits." Please note, however, that not all *covered expenses* are eligible to accumulate toward your medical *out-of-pocket expense* limit. These types of expenses include:

- Prescription *drug copayments*
- Penalty for non-*emergency* use of *hospital* emergency room
- Penalty for non-precertification

Reimbursement for these types of *covered expenses* will continue at the percentage payable shown in the "Schedule of Medical Benefits," subject to the *Plan* maximums.

In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the "Schedule of Medical Benefits" section. Expenses in excess of these *plan* limits will not accumulate toward the medical *out-of-pocket expense* limit. Once you have paid the medical *out-of-pocket expense* limit for eligible expenses *incurred* during a *plan year,* the *Plan* will reimburse additional eligible *covered expenses incurred* during that year at 100%, or until the *maximum benefit* has been reached.

The *Plan* will not reimburse any expense that is not a *covered expense.* In addition, you must pay any expenses to which you have agreed that are in excess of the *usual, customary and reasonable fees*, and any penalties for failure to comply with requirements of the "Cost Containment Provisions" section or penalties that are otherwise stated in the *Plan*. None of these amounts will accumulate toward your medical *out-of-pocket expense* limit. If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your medical *out-of-pocket* expense limit, please contact INTEGRA Administrative Group, Inc. for assistance.

SCHEDULE OF MEDICAL BENEFITS

Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan.* Reimbursement will be made according to the "Schedule of Medical Benefits," and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, "Medical Covered Expenses" and "Medical Exclusions and Limitations." You may find the "Definitions" section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact INTEGRA Administrative Group, Inc. or the *Plan Administrator* for assistance.

Plan Year Maximum Benefits
The following *Plan Year* maximums apply to each *participant*:

All covered essential health benefits	Unlimited
Chiropractic	20 visits
Home Health Care	100 visits
Residential Treatment Facility	100 days
Skilled Nursing/Rehabilitation Facility	100 days
Therapies: Occupational, Physical, Speech, Chiropractic, and Cardiac	60 visits per *plan year combined*

Deductibles, Percentage Payable and Medical out-of-pocket Expense Limits
The following amounts are applied per *participant* per *Plan Year*:

	PPO Network Providers	***Non-PPO Network Providers***
Deductible		
• Individual	$250	Not Applicable
• *Family Unit*	$500	Not Applicable
Medical out-of-pocket Expense Limit		
• Individual	$1,500	Not Applicable
• *Family Unit*	$3,000	Not Applicable

The *Plan Year Medical out-of-pocket Expense* Limit includes the medical *deductible,* medical *co-payments* and *coinsurance.* Medical *Co-payments* will NOT continue to be required after the *medical out-of-pocket* maximum has been reached.

***Plan Year* means January 1 through December 31.**

Payment Levels and Limits
The *deductible* will apply to *covered expenses* as noted in this section.

Hospital Inpatient Services:

Percentage Payable For:	*PPO Network Providers*	Non-*PPO Network Providers*	Limits:
Medical/Surgical Room & Board & Ancillary **(Subject to Pre-Certification - Maximum Penalty for Non-Compliance is $150)**	*Deductible* applies 80%	No benefit	Paid according to the semi-private room rate.
Intensive Care Unit Room & Board **(Pre-certification required)**	*Deductible* applies 80%	No benefit	
Extended Skilled Nursing Facility, Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Combined with Rehabilitation Facility, limited to 100 days per *Plan year* maximum. Paid according to the semi-private room rate.
Rehabilitation Facility Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Combined with Extended Skilled Nursing Facility, limited to 100 days per *Plan year* maximum. Paid according to the semi-private room rate.

Hospital Newborn Care:

Percentage Payable For:	*PPO Network Providers*	Non-*PPO Network Providers*	Limits:
Neo-Natal Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	
Newborn Nursery & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	

Hospital Mental or *Nervous Disorder & Substance Abuse* Services:

Percentage Payable For:	*PPO Network Providers*	Non-*PPO Network Providers*	Limits:
Mental or Nervous Disorder Inpatient Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Paid according to the semi-private room rate.

Substance Abuse Care *Inpatient* Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Paid according to the semi-private room rate.
Residential Treatment Facility, Room & Board & Ancillary **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Limited to 100 days per *Plan year* maximum. Paid according to the semi-private room rate.

Physician In-*Hospital* Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Physician Medical *Hospital* Visit	*Deductible* applies 80%	No benefit	
Physician Newborn Visit	*Deductible* applies 80%	No benefit	
Consultant Visit	*Deductible* applies 80%	No benefit	
Mental or Nervous Disorder Hospital Visit	*Deductible* applies 80%	No benefit	
Substance Abuse Hospital Visit	*Deductible* applies 80%	No benefit	

Surgical *Inpatient* Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Anesthesia	*Deductible* applies 80%	No benefit	
Obstetrical	*Deductible* applies 80%	No benefit	
Surgeon	*Deductible* applies 80%	No benefit	

Surgical Outpatient Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Anesthesia	*Deductible* applies 80%	No benefit	
Surgeon at P*hysician* office	$10 *Co-payment* 100%	No benefit	

Surgeon at *Hospital/Surgical Facility*	*Deductible* applies 80%	No benefit	

Professional Interpretation Services Inpatient:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Pathologist Fee	100%	No benefit	
Radiologist Fee	100%	No benefit	
Radiologist Fee MRI/ PET/ CT	100%	No benefit	

Professional Interpretation Services Outpatient:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Pathologist Fee	100%	No benefit	
Radiologist Fee	100%	No benefit	
Radiologist Fee MRI/ PET/ CT	100%	No benefit	

Urgent Care Facility Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Urgent Care Facility	$25 *Co-payment* 100%	$25 *Co-payment* 100%	

Hospital Emergency Room Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Emergency Room - Accident/Illness **(E*mergency* use)**	*Deductible* applies 80%	*PPO Network Deductible* applies 80%	
Emergency Room Physician – Accident/ Illness **(E*mergency* use)**	*Deductible* applies 80%	*PPO Network Deductible* applies 80%	
Emergency Room - Accident/Illness ***(*Non-*emergency* use*)***	50%	No benefit	
Emergency Room Physician – Accident/ Illness ***(*Non-*emergency* use*)***	50%	No benefit	

Outpatient Diagnostic Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Diagnostic Laboratory	100%	No benefit	
Diagnostic X-ray	$30 Co-payment 100%	No benefit	
MRI, CAT and PET	$100 Co-payment 100%	No benefit	

Outpatient Facility Fees:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Ambulatory Surgery Center/ Hospital **(Pre-certification required)**	*Deductible* applies 80%	No benefit	

Outpatient Therapy Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Occupational Therapy	$35 Co-payment 100%	No benefit	Limited to 60 visits per *Plan year combined* with Physical Therapy, Speech Therapy, Cardiac Therapy, and Chiropractic visits.
Physical Therapy	$35 Co-payment 100%	No benefit	Limited to 60 visits per *Plan year combined* with Occupational Therapy, Speech Therapy, Cardiac Therapy, and Chiropractic visits.
Speech Therapy	$35 Co-payment 100%	No benefit	Limited to 60 visits per *Plan year combined* with Occupational Therapy, Physical Therapy, Cardiac Therapy, and Chiropractic visits.
Cardiac Rehabilitation	$35 Co-payment 100%	No benefit	Limited to 60 visits per *Plan year combined* with Occupational Therapy, Physical Therapy, Speech Therapy, and Chiropractic visits.
Chemotherapy **(Pre-certification required)**	*Deductible* applies 80%	No benefit	
Radiation Therapy	*Deductible* applies 80%	No benefit	

Physician's Office Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Office Visit Primary Care	$10 *Co-payment* 100%	No benefit	
Office Visit Specialist	$30 *Co-payment* 100%	No benefit	
Allergy Care Serum	*Deductible* applies 80%	No benefit	
Allergy Care Testing	100%	No benefit	
Minor Injections	100%	No benefit	
Diagnostic X-ray	$30 *Co-payment* 100%	No benefit	

Diagnostic Laboratory	100%	No benefit	

Chiropractic Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Chiropractic Visit	$35 Co-payment 100%	No benefit	Limited to 20 visits per *Plan year,* and Limited to 60 visits per *Plan year combined* with Occupational Therapy, Physical Therapy, Speech Therapy, and Cardiac Therapy.

Outpatient *Mental or Nervous Disorder and Substance Abuse* Services:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Mental or Nervous Disorder Office Visit - Outpatient	$10 *Co-payment* 100%	No benefit	
Mental or Nervous Disorder Testing and Evaluation	$30 Co-payment 100%	No benefit	
Social Worker Visit	$10 *Co-payment* 100%	No benefit	
Substance Abuse Visit Outpatient	$10 *Co-payment* 100%	No benefit	

Preventive Care Services, for more preventive care services than listed in this table, and for limitations please visit Health Care Reform Preventive Care Benefits

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Contraceptives	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Qualifying Coronavirus preventive services	100%	100%	For limitations visit Health Care Reform Preventive Care Benefits
Eye Examination, adult	100%	No benefit	
Eye Examination, *child*	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
General Medical Examination	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Gynecology Exam	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits

Hearing Examination, *child*	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Hearing Examination, *adult*	100%	No benefit	
Immunization	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Mammogram (preventive)	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Pap Test	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Preventive Lab Screening	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Preventive X-ray Screening	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Prostate Examination	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Well *Child* Care	100%	No benefit	For limitations visit Health Care Reform Preventive Care Benefits
Hypertension Screening	100%	No benefit	Benefits to begin April 1, 2022, and for age 18 and older.
Pregnant Persons Behavioral Counseling	100%	No benefit	Benefit to begin May 1, 2022.

Other *Covered Expenses*:

Percentage Payable For:	***PPO Network Providers***	**Non-*PPO Network Providers***	**Limits:**
Ambulance — Air Transportation	*Deductible* applies 80%	*PPO Network Deductible* applies 80%	
Ambulance — Ground Transportation	*Deductible* applies 80%	*PPO Network Deductible* applies 80%	
Durable Medical Equipment (Including Prosthetic Devices and Lenses Following Cataract *Surgery)* **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Pre-certification required for items that will cost more than $1,000 to purchase or rent.

Dialysis	*Deductible* applies 80%	No benefit	
Home Health Services **(Pre-certification required)**	*Deductible* applies 80%	No benefit	Limited to 100 visits per *Plan year* maximum
Hospice	*Deductible* applies 80%	No benefit	
Infertility testing	*Deductible* applies 80%	No benefit	
Intravenous infusion therapy **(Pre-certification required)**	*Deductible* applies 80%	No benefit	
Blood and Administration	*Deductible* applies 80%	No benefit	
All Other Covered Expenses	*Deductible* applies 80%	No benefit	
Testing* for the 2019 Novel Coronavirus (COVID-19)	100%	100%	
*For Over-the-Counter (OTC) COVID testing, refer to Schedule of Prescription Drug Benefits.			

MEDICAL COVERED EXPENSES

Please refer to the "Cost Containment Provisions" section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan.* Reimbursement will be made according to the "Schedule of Medical Benefits," and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

***Inpatient* Care**

For medical or *surgical* care of an *illness* or *injury*, the *Plan* will reimburse *covered expenses* for semi-private *room and board* and necessary ancillary expenses. If the *hospital* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to 80% of the private room rate. After 23 observation hours, a confinement will be considered an inpatient confinement.

Covered expenses will include *cardiac care units* and *intensive care units*, when appropriate for the *participant's illness or injury.*

Maternity Care

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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). In no event will an "attending provider" include a plan, hospital, managed care organization, or other issuer.

Benefits are payable in the same manner as for medical or *surgical* care of an *illness*, shown in the "Schedule of Medical Benefits" and this section, and subject to the same maximums.

Newborn Care

Coverage for a newborn *child* will be available only if you have satisfied the requirements for coverage in the "Eligibility for Participation" section.

Covered expenses for newborn *children* include nursery and neo-natal intensive care *room and board*, necessary ancillary expenses, and routine newborn care during the period of *hospital* confinement, including circumcision.

Skilled Nursing (or Extended Care) Facilities Benefits

Covered expenses for *inpatient skilled nursing* or (extended care) *facilities* include semi-private *room and board* accommodations, and necessary ancillary charges.

Rehabilitation Facilities Benefits

Covered expenses for *inpatient rehabilitation facilities* include semi-private *room and board* accommodations and necessary ancillary charges.

Mental or Nervous Disorder and Substance Abuse Inpatient

Substance Abuse or *Mental/Nervous Disorder Inpatient*

Covered expenses for *inpatient* care of *substance abuse or Mental/Nervous disorder* include semi-private *room and board* and necessary ancillary charges. Treatment must be rendered in a *hospital* or *substance abuse treatment facility for substance abuse*. Treatment must be rendered in a *hospital* or *psychiatric treatment facility* for *Mental/Nervous disorder*. If the *hospital* or *substance abuse treatment*

facility or *psychiatric treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for an amount equal to 80% of the private room rate for *inpatient* care.

Residential Treatment Facility Benefits
Covered expenses for *inpatient residential treatment facilities* include semi-private *room and board* accommodations and necessary ancillary charges.

Physicians' In-Hospital Services

In-*Hospital* Medical Services
Covered expenses include professional services rendered by the attending *physician* while the *participant* is *hospitalized*.

In-*Hospital* Concurrent Medical Care
Covered expenses include services rendered concurrently by a *physician* other than the attending *physician* when the *participant* is being treated for multiple, unrelated *illnesses* or *injuries,* or which require the skills of a *physician* specialist.

In-Hospital Consultant Services
Covered expenses include the services of a *physician* consultant when required for the diagnosis or treatment of *an illness* or *injury*.

***Substance Abuse or Mental/Nervous Disorder* In-*Hospital* Medical Care Services**
Covered expenses include professional services rendered by the attending *physician* while the *participant* is *hospitalized*.

Surgical Inpatient and Outpatient Services

Anesthesia Services
Covered expenses include the administration of spinal, rectal or local anesthesia, or a *drug* or other anesthetic agent by injection or inhalation, rendered by a licensed *provider*. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA).

***Surgical* Assistants**
Covered expenses include services by a licensed *physician* who actively assists the operating surgeon in the performance of *surgical procedures* when the condition of the patient and complexity of the *surgery* warrant such assistance. Benefits are also provided for these services when rendered by a licensed *surgical physician's* assistant. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's *usual and reasonable* allowance.

Obstetrical Services
Covered expenses include obstetrical services rendered by the *physician* in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the *Plan* provisions in effect on the date the services are rendered.

***Surgical* Services**
Covered expenses include *surgical procedures*, including treatment for fractures and dislocations and routine pre- and post-operative care. Also included are surgically coded therapeutic injections given in a *physician's* office or *hospital/facility*.

Professional Interpretation Services Inpatient and Outpatient
Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an *illness* or *injury*, unless otherwise provided under "Preventive Care."

Hospital Emergency Room Services
Covered expenses include: Facility charge and ER *Physician* charge for *Emergency* treatment of an *accidental injury/illness*. However, the benefit will lessen if the *Plan* determines the charges include a non-*emergency* use of *hospital* emergency room facilities. Refer to the "Schedule of Medical Benefits" for reduced benefit.

Charges for radiology and pathology, for *emergency surgical* or medical care rendered in the *hospital* emergency room billed by other *providers* will be considered for coverage as listed in the "Schedule of Medical Benefits".

Outpatient Facility Fees
Covered expenses include the following services when provided in an outpatient department of a *hospital* or other *institution*:

Outpatient Diagnostic Examinations
Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an *illness* or *injury*.

Outpatient *Surgery/Ambulatory Surgery Center*
Benefits are provided for charges by a *hospital*, *ambulatory surgical center*, or in a *physician's* office, for services required for a *surgical procedure*. The facility fees may include both services and supplies required for the *surgery*.

Cardiac Rehabilitation
Benefits are provided for cardiac rehabilitation program services when certified as *medically necessary* by the attending *physician* in a treatment program that is appropriate for the *participant's illness*.

Chemotherapy Services
Benefits are provided for administration of chemotherapy treatment, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Occupational Therapy
Benefits are provided for occupation therapy to restore a *participant* to health, or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore and develop the *participant's* ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending *physician* as part of a treatment plan that is appropriate for the *participant's illness* or *injury*.

Physical Therapy
Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following *illness*, *injury* or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the *illness* or *injury*, and which is ordered by the attending *physician*.

Radiation Therapy
Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the *usual, customary and reasonable fee* for materials.

Speech Therapy
Benefits are provided for the evaluation and treatment of *participants* who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a

licensed and certified speech therapist as part of a treatment program which is appropriate for the *illness* or *injury*, to include a learning or *mental disorder,* and which is ordered by the attending *physician*.

***Physician's* Office Services**
Covered expenses include the following services rendered in a *physician's* office:

Office Visits
Benefits are provided for services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury.* Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Allergy Care
Benefits are provided for allergy care given in a *physician's* office. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Minor Injections
Benefits are provided for non-surgically coded injections given in a *physician's* office which are required for the treatment of an *illness* or *injury.* Immunizations and other injections which are not for the treatment of an *illness* or *injury* are not covered unless specified under "Preventive Care" or "*Surgical* Services." Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Diagnostic X-ray and Laboratory Services
Benefits are provided for diagnostic x-ray and laboratory services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury.* Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Chiropractic Care Services
Covered expenses include spinal manipulation and other related therapy treatments performed by a licensed M.D., D.O., or D.C. *Chiropractic care* must be rendered for the active treatment of an *illness* or *injury*. Maintenance care is not covered.

Outpatient Mental or Nervous Disorder and Substance Abuse Services

Outpatient *Mental or Nervous Disorder* Care
Covered expenses include outpatient *mental or nervous disorder* care by a licensed psychologist, psychiatrist, or social worker, if the social worker services are under the direct supervision of a *physician*.

Outpatient Substance Abuse Care
Covered expenses include outpatient *substance ab*use care by a licensed *provider*.

Substance Abuse or *Mental/Nervous Disorder* Partial *Hospitalization*
Covered expenses for partial *hospitalization* of *substance abuse or Mental/Nervous disorder*. Treatment must be rendered in a *hospital* or *substance abuse treatment facility for substance abuse*. Treatment must be rendered in a *hospital* or *psychiatric treatment facility* for *Mental/Nervous disorder*. Treatment lasts more than four (4) hours, but less than twenty-four (24) hours a day, and no charge is made for room and board.

Preventive Care Benefit
Covered expenses include these listed services for preventive care for each *participant*, For a current list of applicable preventive services and specifications/limits visit:

https://www.healthcare.gov/coverage/preventive-care-benefits/

- Contraceptive methods, which are approved by the Food and Drug Administration, to include sterilization procedures and patient education/counseling for all women with reproductive capacity.
- Qualifying **coronavirus preventive services**, which includes COVID-19 vaccine, administration services, and the office visit, even if the *provider* is a nonpreferred *provider*. If additional, non-COVID-19 care is received at the same appointment, those services will be covered at regular plan benefits.
- Eye Examination, adult;
- Eye Examination, *child*;
- General Medical Examination by a *Physician*;
- Genetic screening and evaluation for the BRCA breast cancer gene, when medically necessary;
- Gynecology Examination;
- Hearing Examination, *child*;
- Immunizations;
- Mammogram Test;
- Pap Test;
- Preventive Laboratory Screenings;
- Preventive X-rays;
- Prostate Examination; and
- Well *Child* Care.
- Hypertension screening, age 18 and older, beginning April 1, 2022
- Pregnant persons behavioral counseling, beginning April 1, 2022

Second *Surgical* Opinions
Covered expenses include a second opinion to determine the *medical necessity* for a recommended *surgical procedure*. The *physician* rendering the second opinion must not be affiliated with the *physician* who recommended the *surgical procedure*. A third opinion will be covered if the two opinions differ, and if it is performed by a *physician* who is not affiliated with the *physicians* who have rendered opinions.

Other Covered Expenses

Ambulance Service
Covered expenses include local professional ground ambulance service from your home to a *hospital*, or from the scene of an *accident* or medical *emergency*, to the nearest *institution* able to treat the condition or from one *facility* to another when *medically necessary*.

Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

Air ambulance services will be covered when *medically necessary* to transport the *participant* to the nearest *institution* capable of treating the *illness* or *injury*, if the transportation is connected with an Inpatient confinement (chartered air flights are not covered).

Dialysis
Benefits are provided for kidney dialysis treatment, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Durable Medical Equipment
Covered expenses include rental of *durable medical equipment.* The *Plan* may approve purchase of the equipment at the *Plan Administrator's* discretion. Benefits for rental will not exceed the *usual, customary and reasonable fee* for purchase.

Genetic Testing
Covered expenses include molecular laboratory procedures related to genetic testing for cancer risk histocompatibility/blood typing, neoplasia, hereditary disorders, or other conditions. These services must be certified as *medically necessary* by the attending *physician*, and approved by the *Plan*.

Home Health Care
Covered expenses include home health services when rendered by a licensed and accredited *home health care agency*. These services must be provided through a formal, written home health care treatment plan, certified as *medically necessary* by the attending *physician,* and approved by the *Plan*. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family.
- Physical, occupational, and speech therapy.
- Services provided by a licensed social worker (M.S.W.).
- Services provided by a home health aide. Four (4) hours of home health aide services will be considered one visit.

On-going home health services will require re-certification by the attending *physician* and approval by the *Plan,* at the *Plan Administrator's* discretion, in order to qualify for continued coverage.

The total benefits paid for home health care on a weekly basis may not exceed the amount the *Plan* would have paid if the *participant* had been confined in a *hospital, skilled nursing facility* or other *institution*.

Hospice Care
Covered expenses include hospice care services for a terminally ill *participant* when provided by a *hospice care agency*. The services must be provided through a formal, written hospice care treatment program and certified by the attending *physician* as *medically necessary*. Benefits are provided for:

- *Room and board* for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- Respite services.
- Counseling services by a licensed social worker or a licensed counselor.
- Bereavement counseling by a licensed social worker or a licensed counselor for the *employee* and/or covered *dependent*(s).

The attending *physician* must certify that the *participant* is expected to continue to live for six months or less in order to qualify for this benefit.

If the *participant* lives beyond six months, the *Plan* will approve additional hospice care benefits on receipt of satisfactory evidence of the continued *medical necessity* of the services.

Habilitative Services
Covered expenses include habilitative services, when treated for a congenital or genetic birth defect to enhance the ability to function. This includes a defect existing at or from birth, including a hereditary defect. A congenital or genetic birth defect includes, but is not limited to: autism or an autism spectrum disorder; and, cerebral palsy. Benefits are provided for occupational therapy, physical therapy, and speech therapy. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the *plan*.

Benefits are not available for habilitative services delivered through early intervention and school services.

Infertility Treatment
Covered expenses for infertility treatment include diagnostic x-ray and diagnostic lab only.

Intravenous Infusion Therapy
Benefits are provided for administration, services and supplies related to *Intravenous Infusion Therapy*, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Inpatient Intravenous infusion therapy
Coverage for *inpatient Intravenous Infusion Therapy* is provided under the Hospital Inpatient Benefits and Skilled Nursing (or Extended Care) Facilities Benefits sections of this *plan*.

Outpatient Intravenous Infusion Therapy
Covered expenses include charges made on an outpatient basis for Intrav*enous Infusion Therapy* in:

- An outpatient free-standing *facility* or clinic;
- A *physician's* office; or
- A home setting.

Outpatient *Intravenous Infusion Therapy*, other than chemotherapy, received in a *hospital* setting will not be covered, unless no reasonable alternative outpatient *facility* is available or *medical necessity* requires *hospital* care.

Coverage is subject to the maximums, if any, shown in the Medical Schedule of Benefits.

Other Covered Expenses – COVID-19
2019 Novel Coronavirus (COVID-19)
Covered expenses associated with testing for COVID-19 include the following:

- **Diagnostic Tests.** The following items are covered at 100%, *deductible* waived, as provided in the *Families First Coronavirus Response Act* (*FFCRA*) and *Coronavirus Aid, Relief, and Economic Security Act (CARES Act)* and notwithstanding any otherwise-applicable *medical necessity* or *experimental and/or investigational* requirements, and do not require *pre-certification*. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the *Plan* will pay the cash price publicly posted on the *provider's* website, or such other amount as may be negotiated by the *provider* and *Plan*.
    - In vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy **one** of the following conditions:
        - That are approved, cleared, or authorized by the FDA (including an *emergency* authorization);

  - For which the developer has requested or intends to request *emergency* use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such *emergency* use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;

  - That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or

  - That are deemed appropriate by the Secretary of Health and Human Services.

- Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or *emergency room* visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.

- **Qualifying Coronavirus Preventive Services.** The following items are covered at 100%, *deductible* waived, and do not require *pre-certification*.

  - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and

  - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

- **Telehealth and Other Communication-Based Technology Services.** *Participants* can communicate with their doctors or certain other practitioners without going to the doctor's office in person.

- **Requests for Prescription Refills.** When considering whether to cover a greater-than-30-day-supply of drugs, the *Plan* and its Prescription Drug Plan Administrator will, on a case-by-case, basis, consider each request and make decisions based on the circumstances of the patient.

The above benefits are specific to Diagnosis of COVID-19. *Participants* who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the *Plan*, in accordance with the *Plan's* guidelines.

Members who are being transferred from an inpatient acute hospital setting to a Skilled Nursing Facility or Rehabilitation Facility will have the first 5 days of their stay automatically approved. The provider is still required to submit a request for authorization, and to go through the standard review process. Stays over 5 days must be authorized per the normal process.

Upon the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d, these covered expenses will be considered at regular plan benefits.

Covered Expenses Also Include:

- **Anesthesia services & Hospitalization Services** for Dental treatment for:

  - a *child* under the age of 8 years and is determined by a licensed *dentist*, and the *child's physician* to require necessary dental treatment in a *hospital* or *ambulatory surgical center*

due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective.
  - for an individual with one or more medical conditions that if not rendered in a *hospital* or *ambulatory surgical center* would create significant or undue medical risk.

- **Approved clinical trial.** Services for *routine patient costs* for *approved clinical trials* when in relation to the prevention, diagnosis or treatment of cancer or other *life-threatening* diseases or conditions. The clinical trial must be approved or sponsored by a health-related federal agency.

- **Blood transfusions and blood products,** to the extent not replaced. The Plan will cover expenses in connection with autologous blood acquisition and storage.

- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child.*

- **Cleft lip and cleft palate treatment.** The Plan will cover *medically necessary* services for medical, dental, speech therapy, audiology, and nutrition services for *children* under the age of 18 years, when prescribed by the treating *physician* or *surgeon* and are consequent to treatment of the cleft lip or cleft palate.

- **Cochlear implants.**

- **Diabetes treatment services.** Services, supplies, care or treatment to include diabetes outpatient self-management training and educational services when provided under the direct supervision of a certified diabetes educator or a board- certified endocrinologist. Nutritional counseling must be provided by a licensed dietitian.

- **Enteral Formulas.** The *Plan* will cover prescription and nonprescription enteral formulas for home use, through the age of 24 years, when prescribed by a *physician* and *medically necessary*. Use must be for treatment of inherited diseases of amino acid, organic acid, carbohydrate, or fat metabolism as well as malabsorption originating from congenital defects present at birth or acquired during the neonatal period. Coverage for inherited diseases of amino acids and organic acids shall include food products modified to be low protein.

- **Gender reassignment surgery** and Services related to gender dysphoria or gender transition are covered. Surgery must be pre-authorized in order to be covered. Coverage does not include services considered cosmetic in nature when used to improve the gender-specific appearance of an individual, such as, but not limited to: reduction thyroid chondroplasty; liposuction; rhinoplasty; facial bone reconstruction; face lift; blepharoplasty; voice modification surgery; hair removal/hairplasty; or breast augmentation.

- **Growth hormone therapy** as part of a treatment program approved by the *Plan Administrator*.

- **Morbid Obesity surgical procedures** (e.g., intestinal bypass, stomach stapling, balloon dilation) and the associated care, provided the *participant* has not previously undergone the same or similar procedure in the *lifetime* of the *Plan.* To be eligible for surgery, *participants* must be enrolled in this *Plan* for 2 consecutive years with no break in coverage and be 18 years old or older**.** Bariatric-related surgeries are only covered when managed and performed at a UF Health Direct Care Network *facility* by a UF Health Direct Care Network *physician*.

- **Nutritional Services** when education is required for a disease in which patient self-management is an important component of treatment, and there exists a knowledge deficit regarding the disease

which requires the intervention of a trained health professional. Some examples of such medical conditions include treatment of cardiovascular disease, malnutrition, cancer, cerebral vascular disease, or kidney disease, up to a maximum of 6 visits per *plan year* per person.

- **One set of lenses** (contact or frame-type) following *surgery* for cataracts.

- **Oral surgical procedures**, including:

    - Excision of tumors and cysts of the jaws, cheeks, lips, tongues, 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.

- **Orthotics.** The initial purchase, fitting and repair 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*.

- **Oxygen.**

- **Prenatal vitamins.**

- **Prosthetic devices and supplies**, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the *participant's* physical structure and the current device cannot be made serviceable.

- **R.N. and L.P.N.** private duty nursing services for outpatient care when medically necessary and not custodial in nature. Covered expenses for this service will be included to this extent:

    - **Inpatient Nursing Care.** When the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
    - **Outpatient Nursing Care.** Coverage only as stated under Home Health Care. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

- **Reconstruction of a breast**. The federal Women's Health and Cancer Rights Act, signed into law on October 21, 1998, contains coverage requirements for breast cancer patients who elect reconstruction in connection with a *mastectomy*. The federal law requires group health plans that provide *mastectomy* coverage to also cover breast reconstruction *surgery* and prostheses following *mastectomy*.

  As required by law, you are being provided this notice to inform you about these provisions. The law mandates that individuals receiving benefits for a *medically necessary mastectomy* will also receive coverage for:

    - Reconstruction of the breast on which the *mastectomy* has been performed;

    - *Surgery* and reconstruction of the other breast to produce a symmetrical appearance; and

- Prostheses; and
- Treatment of physical complications at all stages of the *mastectomy*, including lymphedemas.

Benefits for breast reconstruction are subject to the same annual plan *deductibles* and coinsurance provisions that apply to other medical and *surgical* benefits covered under this *plan*.

- **Sleep Disorders.** Charges for sleep studies and treatment of sleep apnea and other sleep disorders, including charges for sleep apnea monitors.
- **Smoking cessation.** Charges for smoking cessation treatment, prescription and over the counter products for the treatment of nicotine addiction.
- **Sterilization procedures, elective.**
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury*.
- **Surgical extraction of bone-impacted teeth**.
- **Telecommunication consultations.** For medical and health-related services provided via telephone and internet.
- **Treatment of temporomandibular joint dysfunction,** Medically Necessary services for care and treatment of jaw joint conditions. Care and treatment shall not include orthodontics, crowns or inlays.
- **Wig,** and charges associated with the initial purchase, when hair loss is a result of chemotherapy or radiation treatment for cancer.

Replacement of Organs/Tissues and Related Services
The *Plan Administrator* strongly recommends that any *participant* who is a candidate for any transplant procedure contact INTEGRA Administrative Group, Inc. before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the *Plan,* before the actual services are rendered.

In addition, the *Plan Administrator* has made arrangements with selected *providers* and *facilities*, where a *participant* may receive care at a negotiated rate. Using selected *providers* and *facilities* will normally result in lower costs to the *Plan* and the *participant*. Please contact INTEGRA Administrative Group, Inc. for additional information about the selected *providers* and *facilities*.

Covered expenses include the following types of transplants:

Solid Organs & Tissue Replacement
Benefits are provided for the transplantation of solid human organs (with other human organs) and related services. This *Plan* excludes transplantation of non-human organs.

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 expenses* under the Plan when the recipient is a *participant*. 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.

Bone Marrow Transplants

Benefits are provided for *medically necessary* bone marrow transplantation procedures, including, but not limited to, synergic and allogenic/homologous bone marrow transplantation, as well as autologous bone marrow transplantation procedures. Services must be accepted within the appropriate oncological specialty and not deemed experimental. Benefits will include costs associated with the donor-patient to the same extent and limitations as costs associated with the insured.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this *summary plan description* for that information.**

"*Accident*" means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

"*Actively at work*" or **"*Active employment*"** means performance by the *employee* of all the regular duties of his or her occupation at an established business location of the *participating employer*, or at another location to which he or she may be required to travel to perform the duties of his or her employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered *actively at work* if employment has been terminated.

"*ADA*" means the American Dental Association.

"Administrative period" means period of time immediately following an *initial measurement period* or a standard measurement period when the *participating employer* determines which "variable hour" and/or "ongoing" *employees* are eligible for coverage and to notify and enroll those eligible *employees.* The *administrative period* lasts 30 days.

"AHA" means the American Hospital Association.

"AMA" means the American Medical Association.

"Ambulatory surgical center" means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of *physicians*, with permanent facilities that are equipped and operated primarily for the purpose of performing *surgical procedures*, with continuous *physician* services and registered professional nursing service whenever a patient is in the *institution*, and which does not provide service or other accommodations for patients to stay overnight.

"Annual enrollment period" means the period as determined by the *employer* each year during which *employees* may make new coverage elections.

"Approved clinical trial" means a clinical trial that is being conducted in relation to the prevention, diagnosis or treatment of cancer or other *life-threatening diseases or conditions*. The clinical trial must be approved or sponsored by a health-related federal agency.

"Assignment of Benefits" shall mean an arrangement whereby the *participant* assigns their right to seek and receive payment of eligible *Plan* benefits, in strict accordance with the terms of this *Plan Document*, to a *Provider*. If a *provider* accepts said arrangement, *Providers'* rights to receive *Plan* benefits are equal to those of a *participant*, and are limited by the terms of this *Plan Document*. However, in no event shall any *assignment of benefits* be construed to confer status as a *participant* in the *Plan*, or to confer standing to sue whether in a direct or representative capacity. Except as provided herein, no claim, including, but not limited to, coverage, breach of fiduciary duty, and/or penalties, is assignable by any *participant* without the written consent of the *Plan*. A *Provider* that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

"Birthing center" means an independent, licensed facility which is certified under the statutory requirements of the given state in which it is located, and provides 24 hour nursing services by registered

graduate nurses and certified nurse midwives. An obstetrician or a *physician* qualified to practice obstetrics with *hospital* admitting privileges must be available for consultation and referral and on call during labor and delivery. A birthing center must be equipped, staffed, and operating for the purpose of providing:

- Family centered obstetrical care for patients during uncomplicated *pregnancy*, delivery, and immediate postpartum periods;
- Care for infants born in the center who are either normal or who have abnormalities which do not impair functions or threaten life; and
- Care for obstetrical patients and infants born in the center who require emergency and immediate life support measures to sustain life pending transfer to a hospital.

A birthing center must have an agreement with an ambulance service and a *hospital* to accept transfer.

"Brand name drug" means drugs produced and marketed exclusively by a particular manufacturer. These names are usually registered as trademarks with the Patent Office and confer upon the registrant certain legal rights with respect to their use.

"Business associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103.

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

"Cardiac care unit" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Certificate of coverage" means a written certification provided by any source that offers medical care coverage, including the *Plan*, for the purpose of confirming the duration and type of an individual's previous coverage.

"Certified Independent Dispute Resolution IDR Entity" shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

"Child(ren)" means, in addition to the *employee's* own blood descendant of the first degree or lawfully adopted child, a child placed with the *employee* in anticipation of adoption, a child who is an *alternate recipient* under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the *employee* has obtained legal guardianship, or a newborn *child* of a covered *dependent child*.

"Chiropractic care" means office visits, manipulations, supplies, heat treatment, cold treatment.

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

"City" means City of Jacksonville.

"Cosmetic" or ***"cosmetic surgery"*** means any *surgery*, service, *drug* or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an *injury*.

"Covered entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103.

"*Covered expense"* means a *medically necessary* service or supply which is *usual, customary and reasonable,* and which is listed for coverage in this *Plan.*

"Covered service" is a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the *maximum allowable charge.*

"Custodial care" means care or confinement provided primarily for the maintenance of the *participant*, essentially designed to assist the participant, whether or not *totally disabled*, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

"Deductible" means an amount of money that must be paid by a *participant* for *covered expenses* before the *Plan* will reimburse additional *covered expenses incurred* during that *plan year.*

"Dentist" means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

"Detoxification" means the process whereby an alcohol-intoxicated person, or person experiencing the symptoms of *substance abuse,* is assisted in a facility licensed by the Department of Health through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with *drugs* as determined by a licensed *physician*, while keeping the physiological risk to the patient to a minimum.

"Diagnostic service" means a test or procedure performed for specified symptoms to detect or to monitor an *illness* or *injury*. It must be ordered by a *physician* or other professional *provider*.

"Drug" means insulin and prescription legend *drugs*. A prescription legend *drug* is a Federal legend *drug* (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription") or a state restricted *drug* (any medicinal substance which may be dispensed only by prescription, according to state law) and which, in either case, is legally obtained from a licensed *drug* dispenser only upon a prescription of a currently licensed *physician*.

"Durable medical equipment" means equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;

- Generally is not useful to a person in the absence of an *illness* or *injury*; and

- Is appropriate for use in the home.

"Effective date" means, January 1, 2018, the original *effective date* of the *Plan*.

"Emergency" means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an *emergency* did exist.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"*Emergency services*" shall mean, with respect to an Emergency Medical Condition, the following:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a *hospital* or of an *independent freestanding emergency department*, as applicable, including ancillary services routinely available to the emergency department to evaluate such *emergency medical condition*; and

- Within the capabilities of the staff and facilities available at the *hospital* or the *independent freestanding emergency department*, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an *independent freestanding emergency department*, to stabilize the patient (regardless of the department of the *hospital* in which such further examination or treatment is furnished).

When furnished with respect to an *emergency medical condition*, *emergency services* shall also include an item or service provided by a *non-network provider* or non-*participating health care facility* (regardless of the department of the *hospital* in which items or services are furnished) after the *participant* is stabilized and as part of *outpatient* observation or an *inpatient* or *outpatient* stay with respect to the visit in which the *emergency services* are furnished, until such time as the *provider* determines that the *participant* is able to travel using non-medical transportation or non-*emergency* medical transportation, and the *participant* is in a condition to, and in fact does, give informed consent to the *provider* to be treated as a *non-network provider*.

"Employee" for purposes of this *Plan,* means a person who fulfils the eligibility requirements of the *employer* as listed in the "Eligibility for Participation" section.

"Essential health benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; *emergency services*; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral

health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. All categories may not be covered by 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:

- 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

- 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

- 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

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

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

"Family unit" means the *employee*, his or her spouse and his or her *dependent children*.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"FMLA leave" means a *leave of absence*, which the *City* is required to extend to an *employee* under the provisions of the *FMLA*.

"Generic drug" means drugs not protected by a trademark, usually descriptive of drug's chemical structure.

"*GINA*" means the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "*genetic information*" means, with respect to any individual, information about:

- Such individual's genetic tests;
- The genetic tests of family members of such individual; and
- The manifestation of a disease or disorder in family members of such individual.

The term "*genetic information*" includes participating in clinical research involving genetic services.

Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes.

Therefore, this *Plan* will not discriminate in any manner with its *participants* on the basis of such genetic information.

"Health Breach Notification Rule" shall mean 16 CFR Part 318.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HIPAA rules" means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

"Home health care" means certain services and supplies required for treatment of an *illness* or *injury* in the *participant's* home as part of a formal treatment plan certified by the attending *physician* and approved by the *Plan Administrator*.

"Home health care agency" means an agency or organization which provides a program of *home health care* and which:

- Is approved as a home health agency under *Medicare*;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
    - It is an agency which holds itself forth to the public as having the primary purpose of providing a *home health care* delivery system bringing supportive services to the home;
    - It has a full-time administrator;
    - It maintains written records of services provided to the patient;
    - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
    - Its employees are bonded and it provides malpractice insurance.

"Hospice Care Agency" means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;
- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an ongoing quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

"Hospital" means an *institution* that meets all of the following requirements:

- It provides medical and *surgical* facilities for the treatment and care of injured or sick persons on an *inpatient* basis;
- It is under the supervision of a staff of *physicians*;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a *hospital*, except that this requirement will not apply in the case of a state tax-supported *institution*;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

The requirement of *surgical* facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such *institution* is accredited as such an *institution* by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

"Illness" means a condition, sickness or disease not resulting from trauma. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

"Immediate relative" means spouse, child, brother, sister or parent of the *participant*, whether by birth, adoption or marriage

"Impregnation and infertility treatment" means artificial insemination, fertility *drugs*, G.I.F.T. (Gamete Intrafallopian Transfer), in-vitro fertilization, or any type of artificial impregnation procedure, whether or not such procedure is successful.

"Incurred" A *covered expense* 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* expenses 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 expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

"Independent freestanding emergency department" shall mean a health care facility that is geographically separate and distinct, and licensed separately, from a *hospital* under applicable state law, and which provides any *emergency services*.

"Initial measurement period" means the initial 12 consecutive calendar month period of employment for a variable hour *employee* that the *participating employer* will use to look-back and determine your employment status for benefit purposes.

"*Injury*" means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an *accident*.

"Inpatient" means any person who, while confined to a *hospital*, is assigned to a bed in any department of the *hospital* other than its outpatient department and for whom a charge for *room and board* is made by the *hospital*.

"Institution" means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, *psychiatric hospital*, *substance abuse treatment center*, alternative birthing center, *home health care* center, or any other such facility that the *Plan* approves.

"Intensive care unit" means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Intravenous infusion therapy" means the intravenous or continuous administration of medications or solutions that are a part of your course of treatment.

"Leave of absence" means a leave of absence of an *employee* that has been approved by his or her *participating employer*, as provided for in the ***participating 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.

"Life-threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"*Lifetime*" is a word that appears in this *Plan* in reference to benefit maximums and limitations. *Lifetime* is understood to mean while covered under this *Plan*. Under no circumstances does *lifetime* mean during the lifetime of the *participant*.

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

"Maximum allowable charge" shall mean the amount payable for a specific covered item under this *Plan*. The *maximum allowable charge* will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprise Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the *maximum allowable charge* will be the *qualifying payment amount*, or an amount deemed payable by a *certified IDR entity* or a court of competent jurisdiction, if applicable. If no such amount exists, an amount determined by applicable state law.

"Medical or Surgical disorder" means any *illness or condition included in the current edition of the International Classification of Diseases (ICD)* published by the U.S. Department of Health and Human Services*, with the exception of the mental disorders classification.*

"Medically necessary" means services or supplies which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;
- Provided for the diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the *participant*, the *participant's physician* or another *provider*; and
- The most appropriate supply or level of service which can safely be provided.

For *hospital* stays, this means that acute care as an *inpatient* is necessary due to the kind of services the *participant* is receiving or the severity of the *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*."

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

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

"Morbid obesity" 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 *participant*.

"Network" means the *Preferred Provider Organization (PPO)* network of *providers* offering discounted fees for services and supplies to *participants*. The *network* will be identified on the *participant's Plan* Identification Card.

"Ongoing employee" means an active *employee*, who is still employed by the *participating employer* and has completed either their *initial measurement period* or their *standard measurement period*.

"Out-of-pocket expense limit" means the cost to the *participant* for *deductibles*, *coinsurance*, *copayments*, excluding penalties and non-*covered expenses*.

"*Partial Hospitalization*" is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts more than four (4) hours, but less than twenty-four (24) hours a day, and no charge is made for room and board.

"Participant" means a covered *employee* and his or her covered *dependents* who are eligible for benefits under the *Plan*.

"Participating employer(s)" means City of Jacksonville; Jacksonville Housing Authority; Northeast Florida Regional Council; and First Coast Workforce Development Consortium.

"Participating health care facility" shall mean a *hospital* or *hospital outpatient* department, critical access *hospital*, *ambulatory surgical center*, or other *provider* as required by law, which has a direct or indirect contractual relationship with the *Plan* with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

"PHI" shall mean Protected Health Information, as enacted pursuant to *HIPAA.*

"Physician" means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

"Plan" means the City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan.

"Plan Administrator" means City of Jacksonville.

"Plan Document" means this *plan document* and *summary plan description*.

"Plan Sponsor" means City of Jacksonville.

"Plan year" is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

"Preferred Provider Organization" or ***"PPO"*** means the network of *providers* offering discounted fees for services and supplies to *participants*. The *network* will be identified on the *participant's Plan* Identification Card.

"Pregnancy" means childbirth and conditions associated with *pregnancy*, including *complications of pregnancy*. *Pregnancy* for covered *employees* and covered spouses will be covered benefits.

*"**Privacy Standards"*** means the standards for privacy of individually identifiable health information, as enacted pursuant to *HIPAA*.

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

"Psychiatric hospital" means an *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospital*s, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a *physician*;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a *psychiatric hospital*;
- It requires that every patient be under the care of a *physician*; and
- It provides 24-hour-a-day nursing service.

It does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care* or educational care.

"Qualifying payment amount" shall mean the median of the contracted rates recognized by the *Plan*, or recognized by all plans serviced by the *Plan's Third Party Administrator* (if calculated by the *Third Party Administrator*), for the same or a similar item or service provided by a *provider* in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a *qualifying payment amount*, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

"Reasonable" and/or "Reasonableness" shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating *Provider*. Determination that fee(s) or services are reasonable will be made by the *Plan Administrator*, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be *Reasonable*, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in

their consequence for patients, are not *Reasonable*. The *Plan Administrator* retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the *Plan Administrator*. A finding of *Provider* negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not *Reasonable*.

"Recognized amount" shall mean, except for non-*network* air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for non-*network* air ambulance services generally, the *recognized amount* shall mean the lesser of a *provider's* billed charge or the *qualifying payment amount*.

*"**Rehabilitation hospital"*** means an *institution* which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by *Medicare*.

"Residential Treatment Facility" means a *facility* which provides a program of effective *mental or nervous disorder* services or *substance abuse* services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs;
- It provides a program of treatment under the active participation and a direction of *physician*;
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board;
    - Evaluation and diagnosis;
    - Counseling; and
    - Referral and orientation to specialized community resources.

  A *residential treatment facility* that qualifies as a *hospital* is considered a *hospital*.

"Room and board" means an *institution*'s charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are *medically necessary*.

"Routine patient costs" means those costs that are for *medically necessary* services that are needed for the purposes of an *approved clinical trial*, including those provided by doctors, diagnostic or laboratory tests, and other services consistent with the customary standard of patient care and otherwise covered under the *plan*. *Routine patient costs* do NOT include the actual device, equipment, or *drug* that is being studied as part of the clinical trial.

"Security standards" mean the final rule implementing *HIPAA's* Security Standards for the Protection of *Electronic PHI,* as amended*.*

"Stability period" means the 12 consecutive calendar month period that begins after the *administrative period*.

"Standard measurement period" means the 12 consecutive calendar month period that your *participating employer* will use to look-back and determine your employment status for benefit purposes.

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

- 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 patients to self-care in essential daily living activities must be provided.

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

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

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

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

- 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.

"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.

"Substance abuse treatment center" means an *institution* which provides a program for the treatment of *substance abuse* by means of a written treatment plan approved and monitored by a *physician*. This *institution* must be:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral;

- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or

- Licensed, certified or approved as an alcohol or *substance abuse* treatment program or center by a state agency having legal authority to do so.

"Summary plan description" means this *plan document* and *summary plan description*.

"*Third party administrator*" means INTEGRA Administrative Group, Inc.

"Uniformed services" means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary" (U&C) shall mean covered expenses which are identified by the *Plan Administrator*, taking into consideration the fee(s) which the *Provider* most frequently charges the majority of patients for the service or supply, the amount the *Provider* most frequently accepts as payment in full for the service or supply, the cost to the *Provider* for providing the services, the prevailing range of fees charged in the same "area" by *Providers* of similar training and experience for the service or supply, Medicare reimbursement rates, and/or amount(s) the Provider agrees to accept as payment in full.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of *Providers*, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be *Usual and Customary*, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a *participant* by a *Provider* of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The *Plan Administrator* will determine what the *Usual and Customary* charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is *Usual and Customary*.

Usual and Customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the *Plan* using normative data such as, but not limited to, amounts the *Provider* specifically agrees to accept as payment in full, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

"Variable employee" means an *employee*, based on the facts and circumstances at the date the *employee* begins providing services to the *participating employer* (your first day of *active employment*), whose reasonable expectation of average hours per week cannot be determined.

*"**Waiting period"*** means an interval of time during which the *employee* is in the continuous, *active employment* of his or her *participating employer* before he or she becomes eligible to participate in the *Plan*.

MEDICAL EXCLUSIONS AND LIMITATIONS

This Plan will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies:

1. **Abortion.** Services that are incurred directly or indirectly as the result of an elective abortion or when not *medically necessary*.

2. **Absence of coverage.** That would not have been made in the absence of coverage.

    - This includes charges that are submitted to the *Plan* equal to any amount for which the *provider* has discounted fees or has "written off" amounts due.

3. **Acupuncture therapy.** Acupuncture therapy, except as specified in this document.

4. **Biofeedback.**

5. **Chartered air flights**.

6. **Civil insurrection or riot.** Resulting from *injuries* incurred or exacerbated while participating in a civil insurrection or riot**.**

7. **Complications.** That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure.

8. **Corrective shoes.** Arch supports, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their fitting, unless these services are determined to be Medically necessary and if there is a clearly demonstrable radiographic evidence of abnormality due to disease or injury.

9. ***Cosmetic.*** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising there from).

    - This exclusion does not apply to procedures required as the result of an *injury,* or for correction of an abnormal congenital condition.

    - This exclusion does not apply to reconstruction of a breast following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphademas, in a manner determined in consultation with the attending *physician* and the *participant*.

10. **Court-ordered services.** That are ordered by a court, unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.

11. **Counseling.** For counseling, except as specifically the result of a *mental or nervous condition*, for:

    - Marital difficulties
    - Social maladjustment
    - Pastoral issues
    - Financial issues
    - Behavioral issues
    - Lack of discipline or other antisocial action.

12. ***Custodial care.*** For *custodial care*, except as specified.

13. **Deductibles, Copayments and Coinsurance.** That are not payable due to the application of any specified deductible, copayment or coinsurance provisions of the *Plan.*

14. **Dental.** That are related to dental treatment, except as specifically provided in this *Plan*.

15. **Dental *hospital* admissions.** Related to dental *hospital* admissions, unless determined to be *medically necessary* because of a concomitant condition.

16. **Educational.** That are related to education or vocational training**.**

    - This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.

17. **Excess.** That are not payable under the *Plan* due to application of any *Plan* maximum or limit or because the charges are in excess of the *Plan Administrator's* determination of the *usual, customary and reasonable fee* for the particular service or supply.

18. **Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.

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

20. **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:

    - Hypnotists;
    - Naturopaths;
    - Rolfers; and
    - Marriage counselors.

21. ***Experimental.*** That are *experimental.*

    - In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.
    - This exclusion will not apply to expenses directly related to a non-*experimental*, *medically necessary* transplant procedure which is performed during the course of a clinical trial for off-label use of drugs, or the use of *experimental* drugs. Expenses related to the drugs and the clinical trial are excluded.

22. **Eye exercises or training and orthoptics or vision correction.** For eye exercises or training and orthoptics, radial keratotomy**,** keratomileusis or other vision correction procedures.

    - This exclusion does not apply to Aphakic patients.
    - This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
    - This exclusion does not apply to one pair of lenses following cataract *surgery*.

23. **Eyeglasses, contact lenses.** For eyeglasses, contact lenses and fitting, except one pair of lenses following surgery for cataracts.

24. **Food supplements.** Related to food supplements or augmentation, in any form (unless *medically necessary* to sustain life in a critically ill person or as specifically provided in this *Plan*).

25. **Foot care services, routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized *illness*, *injury* or symptoms involving the foot.

26. **Forms.** For the completion of medical reports, claim forms or itemized billings.

27. **Genetic testing and/or counseling.** For genetic testing or counseling, except as specifically stated in this document. This exclusion does not include cancer risk and genetic testing for Breast Cancer (BRCA).

28. **Government services.** To the extent paid, or which the *participant* is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.

29. **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. This exclusion does not include a wig, when hair loss is a result of chemotherapy or radiation treatment for cancer.

30. **Halfway House.** Services provided at a halfway house.

31. **Hearing aids. For** hearing aids **or** devices, or the examination for their prescription and fitting, except as specifically stated in this document.

32. **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.

33. **Illegal acts.** Any injury sustained by the participant during commission of or attempted commission of any act punishable by law as a felony, whether or not the participant is charged or convicted; or which constitutes riot or rebellion except for an injury resulting from an act of domestic violence or a medical, including mental health, condition

34. **Immediate relative.** Provided by an *immediate relative* or an individual residing in your home.

35. **Infertility treatment.** For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility drugs, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, infertility treatment following a sterilization procedure, surrogate mother or donor eggs. This exclusion does not apply to diagnostic x-ray or diagnostic lab charges.

36. ***Intravenous Infusion Therapy***, other than chemotherapy, provided in a *hospital* when the *participant* is not *inpatient*, unless no reasonable alternative outpatient *facility* is available or *medical necessity* requires *hospital* care.

37. **Late Claims.** For which the claim is received by the *Plan* after the maximum period allowed under this *Plan* for filing claims has expired.

38. **Massage therapy.** For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered *illness* or *injury,* and approved as *medically necessary* by the *Plan Administrator*.

39. **Medically unnecessary.** That are not *medically necessary* for the care and treatment of an *injury* or *illness*, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.

40. **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.

41. **Missed appointments.** Related to missed appointments**.**

42. **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

43. **Non-prescription medicines and supplies.** A *drug* or medicine that can legally be bought without a prescription, except for injectable insulin, except to the extent required by the Families First Coronavirus Response Act.

44. **No legal obligation.** That are provided to a *participant* for which the *provider* customarily makes no direct charge or for which the *participant* is not legally obligated to pay.

45. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a *Physician*; or treatment, services or supplies when the *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*.

46. **Not actually rendered.** That are not actually rendered.

47. **Not eligible.** That were rendered or received prior to or after any period of coverage under this *Plan,* except as specifically provided for in this *summary plan description*.

48. **Not specifically covered.** That are not specifically covered under the *Plan.*

49. **Obesity treatment.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness. Specifically excluded are surgical procedures for the treatment of *morbid obesity* including: intestinal bypass; stomach stapling; balloon dilation and associated care for the surgical treatment of *morbid obesity*, if the *participant* has previously undergone the same or similar procedures in the *lifetime* of this *Plan*. Surgical procedures performed to revise, or correct defects related to, a prior intestinal bypass, stomach stapling or balloon dilation are also excluded. *Medically necessary* non-surgical charges for *morbid obesity* will be covered. Furthermore, obesity-related services required to be covered per ACA or other applicable law will be covered.

50. **Outside of the U.S.A.** For any care, services, *drugs* or supplies *incurred* outside of the U.S.A. if the *participant* traveled to such a location for the purpose of obtaining the care, services, *drugs* or supplies. This exclusion will not apply if services are required as *emergency services* as defined by the *Plan*.

51. **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an *illness* or *injury* that are solely for the personal comfort and convenience of the patient.

52. **Penalties.** That are related to failure to comply with any requirements for coverage under this *Plan*, or for any copayment amounts identified as a "penalty" in this *summary plan description*.

53. **Preventive care.** For physical examinations, routine and preventive care**,** except as specifically provided under this *Plan* or as required by applicable law.

54. **Prohibited by law.** For which the *Plan* is prohibited by law or regulation from providing benefits.

55. **Replacement braces.** Replacement of prosthetic devices such as braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the ***participant's*** physical condition to make the original device no longer functional.

56. **Self-inflicted.** Resulting from any intentionally self-inflicted *illness* or *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.

57. **Sex change/Gender reassignment.** The following services, which are considered cosmetic in nature, are not covered when used to improve the gender-specific appearance of an individual. Examples of services which are considered cosmetic include, but are not limited to:

    - Reduction thyroid chondroplasty;
    - Liposuction;
    - Rhinoplasty;
    - Facial bone reconstruction;
    - Face lift;
    - Blepharoplasty;
    - Voice modification surgery;
    - Hair removal/hairplasty;
    - Breast augmentation.

58. **Subrogation, Reimbursement, and/or Third Party Responsibility**. Services, supplies, care, and/or treatment of an *injury* or *sickness* not payable by virtue of the ***Plan's*** subrogation, reimbursement, and/or third party responsibility provisions.

59. **Tax and shipping.** For taxes and shipping charges levied on *medically necessary* items and services. This exclusion does not apply to surcharges required by law to be paid by the *Plan* in applicable states.

60. **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.

61. **Travel.** For travel, even though prescribed by a *physician*.

62. **Trusses, corsets and other support devices.**

63. **Vitamins.** For vitamins, except as specifically provided under this *Plan.*

64. **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom.

65. **Weekend admissions.** For weekend admission (Friday, Saturday or Sunday) to a *hospital* unless due to an *emergency* or if *surgery* is performed within 24 hours of admission.

66. **Without approval.** Furnished without recommendation and approval of a *physician* acting within the scope of his or her license.

67. **Work-related *illness* or *injury.*** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such *illness* or *injury* entitles the *participant* to workers' compensation or similar benefits.

COST CONTAINMENT PROVISIONS

Pre-certification Program for *Inpatient* & *Outpatient* Services
Inpatient care is normally the greatest part of the *Plan's* expenses and can be the most critical part of your treatment. Through the *Plan's* Pre-certification Program, it is possible to work with your attending *physician* to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the *Plan* unnecessary expense.

The Plan's Pre-certification Program also includes certain outpatient services. These typically are services that may not be *covered expenses* or that involve an on-going course of treatment on an outpatient basis. The purpose of pre-certifying these services is to identify non-*covered expenses*, or *Plan* limitations, in advance of incurring the expenses.

The program works by establishing a communication among you, your attending *physician* and the Pre-certification Program administrator (Vālenz) to discuss the proposed course of treatment and any options that may be available for your treatment. The number for Vālenz is 877-608-2200. The Pre-certification Program does not establish your eligibility for coverage under the *Plan*, nor does it approve the services for coverage or reimbursement under the *Plan*.

Because communication is the basis for the program, the *Plan* requires that you contact Vālenz at least 7 days before any non-*emergency inpatient* admission or services of the types listed in this section. The contact may be made by you, a friend or family member, or your *physician* or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section may result in a penalty reducing the benefits otherwise payable.**

Urgent Care or *Emergency* Admissions
Do not delay seeking medical care for any *participant* who has a serious condition that may jeopardize his life or health because of the requirements of this Program. Pre-certification of outpatient *emergency* care is not recommended or required under these circumstances. For urgent, *emergency* admissions, follow your *physician's* instructions carefully, and contact Vālenz within 48 hours of the admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the *Plan* does not require you or a covered *dependent* to obtain approval of a medical service prior to getting treatment for an urgent care or *emergency* situation, there are no *"pre-service urgent care claims"* under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan*'s procedures following the treatment and file the claim as a *"post-service claim."* As noted above, however, you must contact Vālenz within 48 hours of an urgent, *emergency* admission.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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 as applicable).

Concurrent *Inpatient* Review
Once the *inpatient* setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your *physician*, Vālenz will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

Vālenz will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

Penalty
If you fail to notify Vālenz within the time periods described in this section for *Hospitalizations, Inpatient Facility* stays including *Residential Treatment Facility*, *or Outpatient surgical procedures at Hospital or Free-Standing Surgical Facility,* the benefits that otherwise would be available for the facility's expenses under the Plan will be reduced as follows:

- ***Covered expenses*** **will be reduced by $150, and this amount will not accumulate toward any *out-of-pocket expense* limits.**

Non-*emergency* care and services of the types listed below require pre-certification:

- **Hospitalizations**
- **Skilled Nursing/Rehabilitation Facility stays**
- **Residential Treatment**
- **Home Health Care**
- **Durable Medical Equipment**
- **Outpatient surgical procedures at Hospital or Free-Standing Surgical Facility**
- **Outpatient *Intravenous infusion therapy***
- **Chemotherapy**

Oncologic Managed Care
Pre-certification/ Continued stay review. A *participant* must call Vālenz at least 72 hours prior to admission for any oncology treatment or services and prior to inception of any chemotherapy regimen, pre-authorization must be obtained by calling the oncologic pre-authorization administrator at 877-208-5002.

A pre-certification or concurrent review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Case Management Program
In certain circumstances, especially in the case of a very serious *illness* or *injury*, the *Plan* may make available its Case Management Program services to the *participant*. This is strictly a voluntary program; no *participant* is obligated to participate and benefits will not be adversely affected.

Case managers are medical professionals who will work with your attending *physician* to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your *physician* throughout the course of treatment.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

***Plan Year* Maximums**
The following Prescription *out-of-pocket Plan year* maximum applies:

Individual	$1,000
Family	$2,000

Prescription co-payments will NOT continue to be required after the prescription *out-of-pocket* maximum has been reached.

***Plan Year* means January 1 through December 31.**

Prescription Drug Benefits
The following *co-payments* apply for 30 Day Supply at Retail Pharmacy:

Generic	$10 *Co-payment*
Preferred Brand Name	$40 *Co-payment*
Non-Preferred Brand Name	$75 *Co-payment*

The following *co-payments* apply for 90 Day Supply & Maintenance Drugs at Retail Pharmacy or through Mail Order with your Pharmacy Benefit Manager:

Generic	$20 *Co-payment*
Preferred Brand Name	$80 *Co-payment*
Non-Preferred Brand Name	$150 *Co-payment*

See *Plan* ID card for Pharmacy Benefit Manager.

Benefits are provided for the purchase of *drugs* through the *Plan's* Prescription Drug Card Program. The *participant* must purchase the prescription *drugs* through the Prescription Drug Card Program and use either a participating pharmacy or the "mail order option."

PillarRx IPC Copay Assistance Program
A manufacturer assistance program that will cover most or all of the copay amount required for specialty prescription drugs.
Copay Assistance may apply as follows where appropriate.

- Any manufacturer dollars applied will not apply toward the annual out-of-pocket maximum.
- Your out-of-pocket cost per 30-day supply will not exceed set plan design maximum.

<u>COVID-19 Over-the-Counter Tests (OTC Tests)</u>
The *Plan* will cover OTC Tests for the detection of SARS-CoV-2 or the virus that causes COVID-19, which satisfy any **one** of the following conditions:

- That are approved, cleared, or authorized by the FDA (including an *emergency* authorization);
- For which the developer has requested or intends to request *emergency* use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such *emergency* use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
- That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or

- That are deemed appropriate by the Secretary of Health and Human Services.

OTC Tests neither require *pre-certification* nor involve an individualized clinical assessment from a *provider*. The *Plan* will cover up to 8 OTC Tests, per *participant* per 30 days. This quantity limitation does not apply if the OTC Test is acquired with the involvement of or prescription by a *provider*. OTC Tests purchased in *network* are covered by the *Plan* at the point of sale at 100%, *deductible* waived. When the *Plan* is billed for a non-*network* OTC Test, the *Plan* will pay the cash price publicly posted on the *provider's* website, or such other amount as may be negotiated by the *provider* and *Plan*. If the *participant* pays for a non-*network* OTC Test, the *participant* will be limited to reimbursement for the actual out-of-pocket cost of the OTC Test, up to a maximum of $12 per OTC Test. If the OTC Test is acquired with the involvement of or prescription by a *provider* or if the *Plan* has not arranged for adequate *network* access, the *Plan* will reimburse the *participant* at full cost.

The following limitations also apply:

- Coverage will be denied if reasonable evidence exists that the purchase was solely for employment purposes; and

- Coverage will be denied if reasonable evidence exists of fraud, abuse, or that the purchase was made for use by someone other than the *participant* or their *dependents*. **NOTE:** The *Plan* may require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of an OTC Test, including the UPC code for the OTC Test to verify that the item is one for which coverage is required under FFCRA, and/or a receipt from the seller of the test, documenting the date of purchase and the price of the OTC Test. Further, the *Plan* may require a written attestation from the *participant* describing the OTC Test, the price paid by the *participant*, and the intended use (including for whom the OTC Test will be used).

Upon the expiration of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d, these covered expenses will be considered at regular plan benefits.

Covered Prescriptions
Under the Prescription Drug Card Program, *covered expenses* include:

- All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.
- All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- Contraceptive drugs or devices prescribed by a Physician and approved by the FDA for use as a contraceptive. Refer to the "Medical Covered Expenses" section for coverage on procedures for insertion or removal.
- Insulin and other diabetic supplies when prescribed by a Physician. (Zero copay applies)
- Smoking Cessation aids and Nicotine Replacement Therapy prescribed by a Physician and approved by the FDA for the cessation of the use of tobacco products.

Certain *drugs* are not covered, even when prescribed by your *physician*. Please refer to the list of "Excluded Drugs" below.

Authorization Required
Certain *drugs* require prior authorization before the *Plan* will cover them. Please contact your Pharmacy Benefit Manager as listed on your ID card. Reimbursement for these *drugs* following authorization will be made according to the Schedule of Prescription Drug Benefits.

How the Program Works
There are two ways to purchase drugs through the *Plan's* Prescription Drug Card Program. You may save money by using the "mail order option" if you have prescription *drug(s)* that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "pharmacy option"), simply present your *Plan* ID card and pay your portion of the cost (shown in the "Schedule of Prescription Benefits"). The pharmacist will file the claim for you.

- To fill a prescription through the Drug Card Program's "mail order option":

    - Contact your Pharmacy Benefit Manager (see ID card), or your *Plan's* Mail Order Pharmacy directly to register.

    - Ask your *physician* to send a 90-day supply prescription to the Mail Order Pharmacy via fax or e-prescribe system.

- To fill a prescription through the Drug Card Program's "mail order option" via mail in order form:

    - Obtain a copy of the mail order form from your Human Resources Department.

    - Complete the patient profile questionnaire (for your first order only).

    - Ask your *physician* to prescribe the needed medication for a 90-day supply, plus refills.

    - If you are presently taking medication, you will need a new prescription.

    - If you need the medication immediately, **but will be taking it on an on-going basis,** ask your *physician* for two prescriptions: one that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the "mail order option."

    - Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the "Schedule of Prescription Benefits").

Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.

Excluded *Drugs*
The *Plan* will not cover the following *drugs*, even when prescribed by the *participant's physician*:

1. **Abortifacants.**
2. **Administration.** Any charge for the administration of a covered Prescription Drug.
3. **Anorexients.**
4. **Anti-obesity drugs.**
5. **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.
6. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

7. **Contraceptive Devices.** Except for Nuvaring.
8. **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.
9. **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.
10. **Experimental.** Experimental drugs and medicines, even though a charge is made to the *participant*.
11. **FDA.** Any drug not approved by the Food and Drug Administration.
12. **Infertility**. A charge for fertility medication.
13. **Inpatient medication.** A drug or medicine that is to be taken by the *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 Exclusions and Limitations.
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.
19. **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
20. **Vitamins.** Except for the following which require a prescription: prenatal and vitamins with fluoride.

CLAIM PROCEDURES

You will receive a *Plan* identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your *PPO network*, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your *provider* of service. In most cases, your *provider* will file your claim for you. You may file the claim yourself by submitting the required information to:

INTEGRA Administrative Group, Inc.
110 S. Shipley Street
Seaford, Delaware 19973
302-629-3518

Most claims under the *Plan* will be *"post service claims."* A *"post service claim"* is a claim for a benefit under the *Plan* after the services have been rendered. *Post service claims* must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the *provider* of service, or a form approved for use by the ADA, completed by the dentist, including:

- The date of service;
- The name, address, telephone number and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including *PPO network* repricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

A call from a *provider* who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a *covered expense* before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the *Plan*. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Procedures For All Claims
The procedures outlined below must be followed by *participants* to obtain payment of health benefits under this *Plan*.

Health Claims
All claims and questions regarding health claims should be directed to the *third party administrator.* The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the *participant* is entitled to them. The responsibility to process claims in accordance with

the *summary plan description* has been delegated to the *third party administrator*. The *third party administrator* is not otherwise a fiduciary of the *Plan* and does not otherwise have the authority to make decisions involving the use of discretion; provided, however, that the *third party administrator* is a fiduciary with respect to claims and appeals processing as described in this *Plan.*

Each *participant* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* (or *third party administrator*, if applicable) in its sole discretion may require, written proof that the expenses were *incurred* or that the benefit is covered under the *Plan*. If the *Plan Administrator* (or *third party administrator*, if applicable) in its sole discretion shall determine that the *participant* has not *incurred* a *covered expense* or that the benefit is not covered under the *Plan*, or if the *participant* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

Under the *Plan*, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A *"pre-service claim"* is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A *"pre-service urgent care claim"* is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *participant* or the *participant's* ability to regain maximum function, or, in the opinion of a physician with knowledge of the *participant's* medical condition, would subject the *participant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  It is important to remember that, if a *participant* needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the *Plan* for prior approval. The *participant* should obtain such care without delay.

  Further, if the *Plan* does not require the *participant* to obtain approval of a specific medical service prior to getting treatment, then there is no *pre-service claim.* The *participant* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Concurrent Claims. A "Concurrent Claim" arises when the *Plan* has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The *Plan* determines that the course of treatment should be reduced or terminated; or
  - The claimant requests extension of the course of treatment beyond that which the *Plan* has approved.

  Since the *Plan* does not require the *participant* to obtain approval of a medical service in an urgent care situation prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment in an urgent care situation. The *participant* simply follows the *Plan's* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim.*

- Post-service Claims. A "Post-service Claim" is a claim for a benefit under the *Plan* after the services have been rendered.

When Claims Must Be Filed
Post-service claims must be filed with the *third party administrator* within 90 days of the date charges for the service were incurred. Failure to file a claim within this time limit will not invalidate the claim provided that the *participant* submits evidence satisfactory to the *Plan Administrator* that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond one year from the date the charges were *incurred* except in the case of legal incapacity of the *participant*. Benefits are based upon the *Plan's* provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the *third party administrator* in accordance with the *Plan*'s procedures.

The *third party administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *third party administrator* within 45 days from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions
The *Plan Administrator* shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Pre-service Non-urgent Care Claims***:***

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Notification to claimant of insufficient information	5 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	15 days per benefit appeal

The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Plan Administrator* and the claimant (if additional information was requested during the extension period).

Concurrent Claims:

Plan Notice of Reduction or Termination. If the *Plan Administrator* is notifying the claimant of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The claimant will be notified sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Non-urgent Care. If the *Plan Administrator* receives a request from the claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims*:*

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Notification to claimant of insufficient information	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the *Plan Administrator* and the claimant.

Notification of an Adverse Benefit Determination
The *Plan Administrator* shall provide a claimant with a notice, either in writing or electronically containing the following information:

- A reference to the specific portion(s) of the *plan document* and *summary plan description* upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures,
- 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;
- 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);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and
- In the case of denials based upon a 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, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the claimant's medical circumstances.

First Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be addressed as follows:

INTEGRA Administrative Group, Inc.
110 S. Shipley Street
Seaford, Delaware 19973
Fax# 302-629-8600

Upon receipt, an appeal shall be deemed to be filed with the *Plan* provided all of the information listed below is included.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the Employee/claimant;

- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the *Plan*.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The *Plan Administrator* shall provide a claimant with notification in writing or electronically, of a *Plan*'s adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- **Reference to the specific portion(s) of the *plan document* and *summary plan description* on which the denial is based;**
- **The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;**
- 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;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that 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 free of charge upon request;
- A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures;
- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the *Plan*'s adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's

second appeal must be in writing, and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The *Plan Administrator* shall notify the claimant of the *Plan*'s benefit determination on review within the following timeframes:

- Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
- Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim –Pre-service Non-urgent or Post-service.
- Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- Calculating Time Periods. The period of time within which the *Plan*'s determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the *Plan*'s response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on the second appeal, the *Plan Administrator* shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Review
If, for any reason, the *participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *participant* may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan's* claim review procedures have been exhausted.**

External Review
When a *participant* has exhausted the internal appeals process outlined above and the claim involves a medical judgment or rescission of coverage, the *participant* has a right to have that decision reviewed by independent health care professionals who have no association with the *Plan*, the *Plan Sponsor*, or the *plan administrator*. If the adverse benefit determination involves a medical judgment or a rescission of coverage, you may submit a request for external review within **4 months** after receipt of a denial.
For information in order to request external review by independent health care professional please contact:

INTEGRA Administrative Group
110 S. Shipley Street
Seaford, DE, 19973
302-629-3518

For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is *experimental* or investigational, you also may be entitled to file a request for external review of our denial.

Please contact your *Plan Administrator* with any questions on your rights to external review.

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations and other applicable law, applies only to:

- Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the *Plan's* or issuer's requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is *experimental or investigational*; its determination whether a claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a plan or issuer is complying with the nonquantitative treatment limitation provisions of Code § 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

- An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

- A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Appointment of Authorized Representative
A *participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *participant* to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the *participant* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator.* However, in connection with a claim involving urgent care, the *Plan* will permit a health care professional with knowledge of the *participant's* medical condition to act as the *participant's* authorized representative without completion of this form. In the event a *participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *participant,* unless the *participant* directs the *Plan Administrator* or *third party administrator,* in writing, to the contrary.

Physical Examinations
The *Plan* reserves the right to have a *physician* of its own choosing examine any *participant* whose *illness* or *injury* is the basis of a claim. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan Administrator* may reasonably require during the pendency of a claim. The *participant* must comply with this requirement as a necessary condition to coverage.

Autopsy
The *Plan* reserves the right to have an autopsy performed upon any deceased *participant* whose *illness* or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. Dollars, to the covered *employee* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, the *Plan Administrator* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the *Plan Administrator,* is or was providing the care and support of such *employee*.

Assignments
Benefits for medical expenses covered under this *Plan* may be assigned by a *participant* to the *provider;* however, if those benefits are paid directly to the *employee*, the *Plan* shall be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted. In no event shall any *assignment of benefits* be construed to confer status as a *participant* in the *Plan*, or to confer standing to sue whether in a direct or representative capacity. Except as provided herein, no claim, including, but not limited to, coverage, breach of fiduciary duty, and/or penalties, is assignable by any *participant* without the written consent of the *Plan*.

Non-U.S. Providers
Medical expenses for care, supplies or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a *"non-U.S. provider"*) are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a *non-U.S. provider;*
- The *participant* is responsible for making all payments to *non-U.S. providers,* and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the *Plan* in English and in U.S. dollars.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the *Plan's* terms, conditions, limitations or exclusions. Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *participant* or *dependent* on whose behalf such payment was made.

A *participant, dependent, provider*, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, shall return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The *Plan Administrator* shall have the sole discretion to choose who will repay the *Plan* for an erroneous

payment and whether such payment shall be reimbursed in a lump sum. When a *participant* or other entity does not comply with the provisions of this section, the *Plan Administrator* shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the *participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, in its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *participant, provider* or other person or entity to enforce the provisions of this section, then that *participant, provider* or other person or entity agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage

A *participant's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *participant*. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *participant,* as required by the state Medicaid program; and the *Plan* will honor any subrogation rights the state may have with respect to benefits which are payable under the *Plan*.

COVID-19 TOLLING OF PLAN DEADLINES

Important Updates Regarding COVID-19 Relief – Tolling of Certain *Plan* Deadlines

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," notwithstanding any existing *Plan* language to the contrary, the *Plan* will disregard the period from March 1, 2020 until 60 days after:

- The end of the National Emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 5121 *et seq.;* or
- Such other date announced by the Departments of Treasury and/or Labor, for purposes of determining the following periods and dates:
    - The 30-day period (or 60-day period, if applicable) to request special enrollment under *ERISA* section 701(f) and Internal Revenue Code section 9801(f);
    - The 60-day election period for COBRA continuation coverage under *ERISA* section 605 and Internal Revenue Code section 4980B(f)(5);
    - The date for making *COBRA* premium payments pursuant to *ERISA* section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
    - The date for individuals to notify the *Plan* of a qualifying event or determination of disability under *ERISA* section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
    - The date within which individuals may file a benefit claim under the ***Plan's*** claims procedure pursuant to 29 CFR 2560.503-1;
    - The date within which claimants may file an appeal of an Adverse Benefit Determination under the ***Plan's*** claims procedure pursuant to 29 CFR 2560.503-1(h);
    - The date within which claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
    - The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

This period may also be disregarded in determining the applicable date for the ***Plan's*** duty to provide a *COBRA* election notice under *ERISA* section 606(c) and Internal Revenue Code section 4980B(f)(6)(D), however, note that the *Plan* intends to continue to follow all established *COBRA* parameters.

In no instance will the duration of an extension granted under this section exceed one calendar year.

COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this *Plan*.

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 *participant* is covered by this *Plan* and another plan, or the *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. When Medicare is the primary plan, the secondary and subsequent plans will pay the balance due up to 100% of the amount approved by Medicare. If the Medical care provider does not accept Medicare assignment, this plan will pay up to 100% of the amount allowed under this plan.

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 *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:

- Group or group-type plans, including franchise or blanket benefit plans.
- Blue Cross and Blue Shield group plans.
- Group practice and other group prepayment plans.
- Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- 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.
- No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the *Plan* shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This *Plan* shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

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

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

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

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

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

    d. When a child is covered as a *dependent* and the parents are not separated or divorced, these rules will apply:

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

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

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

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

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

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

        iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit

determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

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

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

3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B. If a member fails to enroll with Medicare Part A or Part B upon original effective date, the Plan reserves the right to process as Primary for Part A or Part B until the member shows proof of enrollment of Medicare Part A or Part B.

   For members with date of hire after March 30, 1986, when Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B. When calculating the Plan's secondary Benefits in these circumstances, for administrative convenience the Plan in its sole discretion may treat the provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

   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.

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

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

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

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

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the *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 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 applicable law, 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 *participant* under the Plan.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Benefits Subject to this Provision
This provision shall apply to all benefits provided under any section of this *Plan*.

Payment Condition
The *Plan*, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an *injury, illness* or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their *dependents*, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "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").

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 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 Participant(s) agrees to include the *Plan's* name as a co-payee on any and all settlement drafts. Further, by accepting benefits the 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 Participant shall be a trustee over those *Plan* assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the *Plan* for all benefits paid or that will be paid by the *Plan* on behalf of the 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 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 Participant(s) fails to reimburse the *Plan* out of any judgment or settlement received, the 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 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 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 Participant(s) is entitled, regardless of how classified or characterized, at the *Plan's* discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the *Plan* to any claim, which any Participant(s) may have against any Coverage and/or party

causing the *illness* or *injury* to the extent of such conditional payment by the *Plan* plus reasonable costs of collection. The 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 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 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 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 Participant(s) authorizes the *Plan* to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the *Plan's* name and agrees to fully cooperate with the *Plan* in the prosecution of any such claims. The 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 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 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 Participant's/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 Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The 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 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 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 *injury*, *illness*, Disease or disability.

Participant is a Trustee Over Plan Assets
Any 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 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 Participant is not represented by an attorney, instruct the insurance company or any third party from whom the 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 Participant disputes this obligation to the *Plan* under this section, the Participant or any of its agents or 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 Participant, beneficiary, or the agents or 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 Participant(s) (*incurred*) prior to the liable party being released from liability. The Participant's/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 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.

Excess Insurance
If at the time of *Injury*, *illness*, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this *Plan* shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the *Plan's* Coordination of Benefits section.

The *Plan's* benefits shall be excess to any of the following:

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.

Separation of Funds
Benefits paid by the *Plan*, funds recovered by the Participant(s), and funds held in trust over which the *Plan* has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the 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.

Wrongful Death
In the event that the 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 Participant(s) and all others that benefit from such payment.

Obligations
It is the Participant's/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 to facilitate 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 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 Participant is not represented by an attorney, instruct the insurance company or any third party from whom the 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 Participant over settlement funds is resolved.

If the 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 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 Participant(s).

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

Offset
If timely repayment is not made, or the 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 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 Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the *Plan*. This provision applies even if the Participant has disbursed settlement funds.

Minor Status
In the event the 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 illegality shall not affect the remaining sections of this provision and *Plan*. The section shall be fully severable. The *Plan* shall be construed and enforced as if such invalid or illegal sections had never been inserted in the *Plan*.

AFFORDABLE CARE ACT (ACA) MEASUREMENT METHOD

The look-back measurement method
The *City* uses a look-back measurement method to determine who is a full-time *employee* for purposes of *Plan* coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for *Plan* coverage determinations.

The look-back measurement method involves three different periods:

- An *initial measurement period* for counting your hours of service.
- A *stability period* when the *employee* is either treated as full-time or non-full-time for *Plan* eligibility purposes; and
- An *administrative period* that allows time for *Plan* enrollment and disenrollment. The *City* establishes how long these periods last, subject to IRS parameters.

The rules for look-back measurement method are very complex. The rules vary depending on whether an *employee* is an ongoing *employee* or a new *employee*, and whether a new *employee* is expected to work full time or is a variable, seasonal, or part-time *employee*. The *City* intends to follow the IRS final regulations (including subsequent guidance issued by the IRS on look-back measurement method) when administering the look-back measurement method.

Notwithstanding anything else contained in this section, a part-time *employee* may be eligible for coverage to the extent he or she satisfies the definition of "qualified part-time *employee*" contained in the "Eligibility for Participation" section of this *Plan*.

Ongoing *employees*

For ongoing *employees*, the *City* determines full-time status by looking at the *standard measurement period*. An ***employee's*** hours of service during the *standard measurement period* will determine his or her *Plan* eligibility for the stability period that follows the *standard measurement period.*

An ongoing *employee* is one who has been employed by the *City* for at least one complete *standard measurement period.*

If an ongoing *employee* was employed, on average, for at least 30 hours of service per week, or 130 hours of service per month, during the *standard measurement period*, the *employee* is treated as a full-time *employee* for a set period into the future, known as the *stability period*. This means, as a general rule, that the *employee* is eligible for *Plan* coverage during the *stability period*, regardless of the ***employee's*** number of hours of service during the *stability period*, as long as he or she remains an *employee*.

The final IRS regulations include an exception for certain *employees* who have been continuously offered *Plan* coverage and who transfer to part-time positions during the *stability period*. If certain conditions are met, *Plan* eligibility for these transferred *employees* may end during a *stability period*. The *City* intends to follow applicable IRS guidance, including the rule for changes in employment status, when administering the look-back measurement method.

If an ongoing *employee* was not employed, on average for at least 30 hours of service per week (or 130 hours of service per month) during the *standard measurement period*, the *employee* is not treated as a full-time *employee* during the *stability period,* regardless of the ***employee's*** number of hours of service during the *stability period*.

The *City* also uses an *administrative period* between the *standard measurement period* and the *stability period*. The *administrative period* overlaps with the prior *stability period* to prevent any gaps in coverage for *employees* enrolled in coverage because of their full-time status during the prior *initial measurement period*.

New *employees* expected to work full-time

For a new *employee* who is not a seasonal *employee* and who the *City* reasonably expects at his or her start date to be a full-time *employee*, the *City* will determine the ***employee's*** status as a full-time *employee* based on the ***employee's*** hours of service for each calendar month.

If the ***employee's*** hours of service for the calendar month equal or exceed an average of 30 hours of service per week, or 130 hours of service per month, the *employee* is a full-time *employee* for that calendar month. Once the new *employee* becomes an ongoing *employee* (when he or she has been employed for one *standard measurement period*), the measurement rules for ongoing *employees* will apply.

New variable hour, seasonal, or part-time *employees*

Under the look-back measurement method, the *City* determines whether new variable hour *employees*, new seasonal *employees*, and new part-time *employees* are full-time *employees* by measuring their hours of service during an *initial measurement period*.

- An *employee* is a variable hour *employee* if, at the ***employee's*** start date, the *City* cannot determine whether the *employee* is reasonably expected to be employed, on average, at least 30 hours per week because the ***employee's*** hours are variable or otherwise uncertain.

- A seasonal *employee* is generally an *employee* who is hired into a position for which the customary annual employment is six months or less. Also, the period of employment for a seasonal *employee* should begin each calendar year in approximately the same part of the year, such as summer or winter.

- A part-time *employee* is a new *employee* who the *City* reasonably expects to be employed, on average, less than 30 hours per week during the *initial measurement period.*

Similar to the method for ongoing *employees*, the look-back measurement method for variable hour, seasonal, and part-time *employees* utilizes a *stability period* for when coverage may need to be provided, depending on the ***employee's*** hours of service during the *initial measurement period.* An *administrative period* is also used to make eligibility determinations and notify and enroll *employees*.

If a new variable hour, seasonal, or part-time *employee* was employed, on average, at least 30 hours of service per week, or 130 hours of service per month, during the *initial measurement period*, the *employee* is treated as a full-time *employee* for a set period into the future, known as the *stability period*. This means that the *employee* is eligible for *Plan* coverage during the *stability period*, regardless of the ***employee's*** number of hours of service during the *stability period*, as long as he or she remains an *employee*.

If a new variable hour, seasonal, or part-time *employee* was not employed, on average, at least 30 hours of service per week (or 130 hours of service per month), during the *initial measurement period*, the *employee* is not treated as a full-time *employee* during the *stability period*, regardless of the number of hours of service during the *stability period*.

The final IRS regulations contain special rules for a new variable hour, seasonal, or part-time *employee* who, before the end of the *initial measurement period*, changes employment to a position or status where if the *employee* had started employment in the new position or status, he or she would have reasonably been expected to be employed full-time as a non-seasonal *employee*. The

City intends to follow applicable IRS guidance, including the special rules for changes in employment status, when administering the look-back measurement period.

The *City* also uses an *administrative period* between the *initial measurement period* and the *stability period*.

Once a new variable hour, seasonal, or part-time *employee* has been employed for an entire *standard measurement period*, the *employee* will be tested for full-time status, beginning with the *standard measurement period*, at the same time and under the same conditions as other ongoing *employees*.

Rehired *employees* and *employees* returning from unpaid leave

- If an *employee* goes at least 13 consecutive weeks without an hour of service and then earns an hour of service, he or she is treated as a new *employee* for purposes of determining the ***employee's*** full-time status under the look-back measurement method. The *City* will apply a rule of parity for periods of less than 13 weeks. Under the rule of parity, an *employee* is treated as a new *employee* if the period with no credited hours of service is at least four weeks long and is longer than the ***employee's*** period of employment immediately before the period with no credited hours of service.

- For an *employee* who is treated as a continuing *employee*, the *measurement* and *stability periods* that would have applied to the *employee* had he or she not experienced the break in service will continue to apply upon the ***employee's*** resumption of service.

In addition, a special averaging method applies when the *measurement period* includes special unpaid leave (i.e., *FMLA*, *USERRA*, or jury duty). This method only applies to an *employee* who is treated as a continuing *employee* upon resuming services for the *participating employer*, and not to an *employee* who is treated as terminated and rehired. Under the averaging method, the *City* will either:

- Determine the average hours of service per week for the *employee* during the *measurement period*, excluding the special unpaid leave period, and use that average as the average for the entire *measurement period*; or

- Treat the *employee* as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the *employee* was credited with hours of service during the weeks in the *measurement period* that are not special unpaid leave.

PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Patient Protection Notices
The *Plan* generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the *Network* and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the *Network* who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the number on the back of your ID card.

Status Under Health Care Reform Law
The *Plan* is not considered grandfathered for purposes of the Affordable Care Act. Consequently, the *Plan* must provide for the following to comply with the ACA:

- **The elimination of any overall *lifetime* maximum** on the dollar value of essential health benefits that may have previously applied.
- **The elimination of any overall *annual* maximum** on the dollar value of essential health benefits that may have previously applied.

  NOTE: Lifetime or annual maximums may continue to apply to specific services if they are not considered essential health benefits. For guidelines on which services are considered "essential health benefits" contact Integra Administrative Group, Inc.
- **Coverage for adult dependents until 26,** regardless of whether the dependent is unmarried, married or is a student. The provision of the law does not require coverage for children of Covered Dependents. Florida law provides additional coverage for adult dependents (from the age of 26 through the end of the year in which they turn 30), who meet certain eligibility criteria as set forth in this *summary plan description*.
- **Coverage for preventive benefits with no member cost-sharing.** When preventive services are received from a *Network* provider, program deductibles, copayments or coinsurance will no longer apply. For a service such as a colonoscopy, related services such as operating room and anesthesia charges will also be covered at no cost to the member. For guidelines on which preventive services are affected, please consult http://www.heathcare.gov/ and search under Preventive Care.

- **Revisions to the appeals process**. An updated appeal process that complies with the new health care reform regulations now applies. For example, if an appeal is denied internally, covered employees will now be able to request a further review by an independent external review entity.

COBRA CONTINUATION COVERAGE

The right to *COBRA continuation coverage* was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("*COBRA*"). *COBRA continuation coverage* can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the *Plan* when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your *dependents* fail to make timely payment of premiums. You should check with your *participating employer* to see if *COBRA* applies to you and your *dependents*.

COBRA continuation coverage
"*COBRA continuation coverage*" is a continuation of *Plan* coverage when coverage otherwise would end because of a life event known as a "*qualifying event*." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer's* plan) are not considered for continuation under *COBRA*.

Qualifying Event
Specific *qualifying event*s are listed below. After a *qualifying event*, *COBRA continuation coverage* must be offered to each person who is a "*qualified beneficiary*." You, your spouse, and your *dependent children* could become *qualified beneficiaries* if coverage under the *Plan* is lost because of the *qualifying event*.

If you are a *covered employee* (meaning that you are an employee and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because either one of the following *qualifying event*s happens:

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

If you are the spouse of a *covered employee*, you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because any of the following *qualifying event*s happens:

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

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying event*s happens:

- The parent-*covered employee* dies;
- The parent-*covered employee*'s hours of employment are reduced;
- The parent-*covered employee*'s employment ends for any reason other than his or her gross misconduct;
- The parent-*covered employee* becomes entitled to *Medicare* benefits (Part A, Part B, or both);

- The parents become divorced; or

- The child stops being eligible for coverage under the plan as a "*dependent child*."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a *qualifying event*. If a proceeding in bankruptcy is filed with respect to City of Jacksonville, and that bankruptcy results in the loss of coverage of any retired employee covered under the *Plan*, the retired employee will become a *qualified beneficiary* with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become *qualified beneficiaries* if bankruptcy results in the loss of their coverage under the *Plan*.

The *participating employer* must give notice of some *qualifying events*
When the *qualifying event* is the end of employment, reduction of hours of employment, death of the *covered employee*, commencement of a proceeding in bankruptcy with respect to the employer, or the *covered employee*'s becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *participating employer* must notify the *Plan Administrator* of the *qualifying event*.

You must give notice of some *qualifying events*
Each *covered employee* or *qualified beneficiary* is responsible for providing the *Plan Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a *qualifying event* that is a divorce of a *covered employee* (or former employee) from his or her spouse;

- Notice of the occurrence of a *qualifying event* that is an individual's ceasing to be eligible as a *dependent* under the terms of the *Plan*;

- Notice of the occurrence of a second *qualifying event* after a *qualified beneficiary* has become entitled to *COBRA continuation coverage* with a maximum duration of 18 (or 29) months;

- Notice that a *qualified beneficiary* entitled to receive *COBRA continuation coverage* with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of *COBRA continuation coverage*; and

- Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The *Plan Administrator* is:

City of Jacksonville
117 West Duval Street, Suite 150
Jacksonville, Florida 32202
904-630-1314

A form of notice is available, free of charge, from the *Plan Administrator* and must be used when providing the notice.

Deadline for providing notice
For *qualifying event*s described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date on which the relevant *qualifying event* occurs;

- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

For the disability determination described above, the notice must be furnished by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;

- The date on which a *qualifying event* occurs;

- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

In any event, this notice must be furnished before the end of the first 18 months of *COBRA continuation coverage*.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or

- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan*'s *summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan*'s procedures for providing such notice to the *Plan Administrator*.

The notice must be postmarked (if mailed), or received by the *Plan Administrator* (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend *COBRA continuation coverage* is lost, and if you are electing *COBRA continuation coverage*, your coverage under the *Plan* will terminate on the last date for which you are eligible under the terms of the *Plan*, or if you are extending *COBRA continuation coverage*, such coverage will end on the last day of the initial 18-month *COBRA continuation coverage* period.

Who can provide the notice
Any individual who is the *covered employee* (or former employee), a *qualified beneficiary* with respect to the *qualifying event*, or any representative acting on behalf of the *covered employee* (or former employee) or *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the *qualifying event*.

Required contents of the notice
The notice must contain the following information:

- Name and address of the *covered employee* or former employee;

- If you already are receiving *COBRA continuation coverage* and wish to extend the maximum coverage period, identification of the initial *qualifying event* and its date of occurrence;

- A description of the *qualifying event* (for example, divorce, cessation of dependent status, entitlement to *Medicare* by the *covered employee* or former employee, death of the *covered employee* or former employee, disability of a *qualified beneficiary* or loss of disability status);

- In the case of a *qualifying event* that is divorce, name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*, date of divorce, and a copy of the decree of divorce;

- In the case of a *qualifying event* that is *Medicare* entitlement of the *covered employee* or former employee, date of entitlement, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;

- In the case of a *qualifying event* that is a dependent child's cessation of dependent status under the *Plan*, name and address of the child, reason the child ceased to be an eligible *dependent* (for example, attained limiting age, lost student status, married or other);

- In the case of a *qualifying event* that is the death of the *covered employee* or former employee, the date of death, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;

- In the case of a *qualifying event* that is disability of a *qualified beneficiary*, name and address of the disabled *qualified beneficiary*, name(s) and address(es) of other family members covered under the *Plan*, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

- In the case of a *qualifying event* that is loss of disability status, name and address of the *qualified beneficiary* who is no longer disabled, name(s) and address(es) of other family members covered under the *Plan*, the date the disability ended and the date of the SSA's determination; and

- A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no *COBRA continuation coverage*, or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. If the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, the *Plan Administrator* may reject the notice if it does not contain enough information for the *Plan Administrator* to identify the plan, the *covered employee* (or former employee), the *qualified beneficiaries*, the *qualifying event* or disability, and the date on which the *qualifying event*, if any, occurred.

Electing *COBRA continuation coverage*

Complete instructions on how to elect *COBRA continuation coverage* will be provided by the *Plan Administrator* within 14 days of receiving the notice of your *qualifying event*. You then have 60 days in which to elect *COBRA continuation coverage*. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If *COBRA continuation coverage* is not elected in that 60-day period, then the right to elect it ceases.

Each *qualified beneficiary* will have an independent right to elect *COBRA continuation coverage*. *Covered*

*employee*s may elect *COBRA continuation coverage* on behalf of their spouses, and parents may elect *COBRA continuation coverage* on behalf of their *children*.

In the event that the *Plan Administrator* determines that the individual is not entitled to *COBRA continuation coverage*, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to *COBRA continuation coverage*.

***COBRA continuation coverage* time period**
COBRA continuation coverage will be available up to the maximum time period shown below. Multiple *qualifying event*s which may be combined under *COBRA* will not continue coverage for more than 36 months beyond the date of the original *qualifying event*. When the *qualifying event* is "entitlement to *Medicare*," the 36-month continuation period is measured from the date of the original *qualifying event*. For all other *qualifying event*s, the continuation period is measured from the date of the *qualifying event*, not the date of loss of coverage.

When the *qualifying event* is the death of the *covered employee* (or former employee), the *covered employee*'s (or former employee's) becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a *dependent child*, *COBRA continuation coverage* lasts for up to a total of 36 months.

When the *qualifying event* is the end of employment or reduction of the *covered employee*'s hours of employment, and the *covered employee* became entitled to *Medicare* benefits less than 18 months before the *qualifying event*, *COBRA continuation coverage* for *qualified beneficiaries* other than the *covered employee* lasts until 36 months after the date of *Medicare* entitlement. For example, if a *covered employee* becomes entitled to *Medicare* 8 months before the date on which his or her employment terminates, *COBRA continuation coverage* for his or her spouse and children can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the *qualifying event* (36 months minus 8 months).

Otherwise, when the *qualifying event* is the end of employment (for reasons other than gross misconduct) or reduction of the *covered employee*'s hours of employment, *COBRA continuation coverage* generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of *COBRA continuation coverage* can be extended.

Disability extension of 18-month period of *COBRA continuation coverage*
If you or anyone in your family covered under the *Plan* is determined by the SSA to be disabled and you notify the *Plan Administrator* as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of *COBRA continuation coverage*, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of *COBRA continuation coverage* and must last at least until the end of the 18-month period of *COBRA continuation coverage*.

Second qualifying event extension of 18-month period of *COBRA continuation coverage*
If your family experiences another *qualifying event* while receiving 18 months of *COBRA continuation coverage*, the spouse and *dependent* children in your family can get up to 18 additional months of *COBRA continuation coverage*, for a maximum of 36 months, if notice of the second *qualifying event* properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent children* receiving *COBRA continuation coverage* if the *covered employee* or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the *Plan* as a *dependent child*, but only if the event would have caused the spouse or dependent child to lose coverage under the *Plan* had the first *qualifying event* not occurred. An extra fee will be charged for this extended *COBRA continuation coverage*.

Reasons *COBRA continuation coverage* can end earlier than the maximum periods above
COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

- The date your *participating employer* ceases to provide a group health plan to any employee;

- The date on which coverage ceases by reason of the *qualified beneficiary*'s failure to make timely payment of any required premium;

- The date that the *qualified beneficiary* first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either *Medicare* Part A or Part B (whichever comes first) (except as stated under *COBRA*'s special bankruptcy rules); or

- The first day of the month that begins more than 30 days after the date of the SSA's determination that the *qualified beneficiary* is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for *COBRA continuation coverage*
Once *COBRA continuation coverage* is elected, you must pay for the cost of the initial period of coverage within 45 days. To continue coverage timely payments must be made no later than 30 days after the first day of the coverage period. If a payment is not received within 30 days of the due date, *COBRA continuation coverage* will be canceled and will not be reinstated.

Cost of *COBRA continuation coverage*
Your monthly cost is the full cost, including both *employee* and employer costs, plus a 2% administrative fee and other costs as permitted by law. Note, however, that the cost for *COBRA continuation coverage* provided during the disability extension described above is the full cost, including both *employee* and employer costs, plus a 50% administrative fee and other costs as permitted by law.

Current Addresses
In order to protect your family's rights, you should keep the *Plan Administrator* (who is identified above) informed of any changes in the addresses of family members.

PLAN ADMINISTRATION

Plan Administrator duties

The *Plan* is administered by the *Plan Administrator* in accordance with this plan document and summary plan description, and applicable law. The *Plan Administrator* has retained the services of the *Third Party Administrator* to provide certain claims processing and certain administrative services. 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* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will 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* will 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 *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* (or, to the extent applicable, the *Third Party Administrator*) decides, in its discretion, that the *participant* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *participant's* rights;
- 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;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan*'s administration.

Plan Changes

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* may, in its sole discretion, at any time, amend, suspend or terminate the *Plan* in whole or in part. This includes amending the benefits under the *Plan*.

Any such amendment, suspension or termination shall be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which shall be acted upon as provided in the *Plan Sponsor's* articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by applicable law. In the event that the *Plan Sponsor* is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the *Plan* is terminated, the rights of *participants* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

MISCELLANEOUS INFORMATION

Funding of the Plan
The *Plan Sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan Sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *participant's* contribution (if any) will be determined from time to time by the *Plan Sponsor*, in its sole discretion.

Information Release
For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *participant* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *participant* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

Clerical Errors
Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *participants* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity to Applicable Law
This *Plan* shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*. It is intended that the *Plan* will conform to the requirements of applicable law, as it applies to employee welfare plans, as well as any other applicable law.

Fraudulent Claim
The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a *participant* in the *Plan*;
- Attempting to file a claim for a *participant* for services that were not rendered or *drugs* or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

Rescission
This *Plan* will rescind coverage only due to fraud or an intentional misrepresentation of a material act. Rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective

effect or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premiums or costs of coverage.

Document Interpretation
The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Participants* are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this *summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

Plan Provision Waiver
No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan is not a Contract of Employment
This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of employment between the *employer* and any *participant* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

Worker's Compensation
This *Plan* excludes coverage for any i*njury* or *illness* that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such *injury* or *illness*. However, if benefits are paid by the *Plan* and it is later determined that you received or are eligible to receive workers' compensation coverage for the same *injury* or *illness*, the *Plan* is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the *injury* or *illness* regardless of the amount or terms of any settlement you receive from workers' compensation. The *Plan* will exercise its right to recover against you. The *Plan* reserves its right to exercise its rights under this section and the section entitled "Recovery of Payments" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;
- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the *Plan Administrator* immediately when you file a claim for coverage under workers' compensation if a claim for the same *injury* or *illness* is or has been filed with this *Plan*. Failure to do so, or to reimburse the *Plan* for any expenses it has paid for which coverage is

available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the *Plan* for recovery and disciplinary action.

Alternate Treatment by Plan's Discretion
The *Plan Administrator* may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this *Plan,* be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply. Such payments will be considered as being in accordance with the terms of this *summary plan description*.

If a *participant*, in cooperation with his or her *provider*, elects a course of treatment that is deemed by the *Plan Administrator*, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the *illness* or *injury*, this *Plan* will allow coverage for the *usual, customary and reasonable* value of the less costly or extensive course of treatment.

DISCRIMINATION IS AGAINST THE LAW

The City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Kevin McDaniel, Chief, ADA Coordinator, Disabled Services Division, City of Jacksonville, telephone: (904) 630-4940; email: klmcdan@coj.net; or online at www.jaxada.com.

If you believe that the City of Jacksonville UF Health Direct Care Employee Health and Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Kevin McDaniel, Chief/ADA Coordinator, Disabled Services Division, City of Jacksonville, 117 West Duval Street, Suite 205, Jacksonville, FL 32202; telephone number: (904) 630-4940 (TTY number: (904) 630-4933); fax: (904) 630-3476; email: klmcdan@coj.net; or online at www.jaxada.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kevin McDaniel, Chief/ADA Coordinator, Disabled Services Division, is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html**.**

Michelle's Law
Michelle's Law applies to group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law was effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the group health plan as a student but lose their student status because they take a medically necessary leave of absence.

As a result, if your child is no longer a student, as defined in the *Plan*, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the *Plan* for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the

first day of the leave of absence, your child was (1) covered under the *Plan* and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

- begins while the child is suffering from a serious illness or injury,
- is medically necessary, and
- causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

- is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the *Plan* would otherwise terminate, and
- stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the *Plan* is changed during this one-year period, the *Plan* must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the *Plan* no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child’s treating physician must provide a written certification to the *Plan* stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA Continuation Coverage **–** If your child is eligible for Michelle's Law's continued coverage and loses coverage under the *Plan* at the end of the continued coverage period, continuation coverage under COBRA will be available at the end of Michelle's Law's coverage period and a COBRA notice will be provided at that time.

Mental Health Parity and Addiction Equity Act
Notwithstanding anything in the Plan to the contrary, to the extent required by law, the *Plan* will comply with the Mental Health Parity and Addiction Equity Act (“MHPAEA”), including, but not limited to, not imposing any lifetime or annual limits on mental health benefits that violate the applicable requirements of MHPAEA. This law precludes group health plans from imposing financial requirements and treatment limitations on mental health or substance abuse benefits that are more restrictive than financial requirements and treatment limitations on medical and surgical benefits. MHPAEA also may prevent the *Plan* from placing annual or lifetime dollar limits on mental health and substance abuse benefits that are less favorable than annual or lifetime dollar limits for medical and surgical benefits offered under the plan.

Although the law requires "parity", or equivalence, with regard to annual and lifetime dollar limits, financial requirements and treatment limitations, MHPAEA does not require group health plans and their health insurance issuers to include these benefits in their medical plan.

Key changes made by MHPAEA include the following:

- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) that apply to mental health and substance

abuse benefits must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical and surgical benefits;

- Mental health and substance abuse benefits may not be subject to any separate cost sharing requirements or treatment limitations that only apply to such benefits;
- If a group health plan includes medical and surgical benefits and mental health and substance abuse benefits, and the plan provides for out of network medical and surgical benefits, it must provide for out of network mental health and substance abuse benefits; and
- Standards for medical necessity determinations and reasons for any denial of benefits relating to mental health and substance abuse benefits must be disclosed upon request.

Prescription Drug Coverage and Medicare
This notice has information about your current prescription drug coverage with the City and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan, you may keep your current prescription drug coverage or you may choose to drop it. Prescription drug coverage is automatically included as part of your overall coverage under the *Plan*. In order to drop your prescription drug coverage, you would therefore have to drop your coverage under the entire medical plan. If you do choose to drop your coverage under the Plan (including your prescription drug coverage), be aware that you will not be able to get this coverage back.

You should compare your current prescription drug coverage, including which drugs are covered, with the coverage and cost of Medicare prescription drug plans in your area.

If you drop or lose your coverage under the *Plan* (including your prescription drug coverage) and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay.

You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next October 15th to enroll.

For more information about this notice or your current prescription drug coverage contact Employee Benefits. You may receive this notice at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through City changes. You also may request a copy from Employee Benefits at any time.

For more information about your options under Medicare prescription drug coverage: More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. Every year, you should receive a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans by:

- Visiting www.medicare.gov for personalized help,
- Calling your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for telephone numbers), or
- Calling 1-800-MEDICARE (1-800-633-4227); TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

HIPAA PRIVACY PRACTICES

Rules Regarding Use and Disclosure of Protected Health Information

Use and Disclosure of Protected Health Information
The *Plan* will use or disclose "Protected Health Information" (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the regulations issued thereunder, as amended from time to time, including 45 CFR Parts 160 and 164, subparts A, D and E (HIPAA Privacy Rule) and 45 CFR Parts 160 and 164, subpart C (HIPAA Security Rule).

Use and Disclosure of PHI as Permitted by Authorization of the Participant or Beneficiary
As soon as practicable following the receipt of an authorization from a *participant* or his or her duly appointed personal representative, the *Plan* will disclose PHI in accordance with the authorization.

Disclosure to the City
Upon request of the City, the *Plan* will disclose summary health information and enrollment and disenrollment information to the City as permitted pursuant to Section 164.504 of the HIPAA Privacy Rule.

The *Plan* will disclose PHI other than summary health information and enrollment and disenrollment information for purposes related to "plan administration," "treatment," "payment" and "health care operations" as described above to the City only upon receipt of a certification from the City that the applicable *Plan* documents have been amended to incorporate the provisions set forth in the remaining portions of this section.

To receive PHI as described in the preceding paragraph, the City shall certify to the *Plan* that it agrees to:

- not use or further disclose PHI other than as permitted or required by the *Plan* document or as required by law;
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that the City creates, receives, maintains, or transmits on behalf of the *Plan*;
- ensure that any agents, including a subcontractor, to whom the City provides PHI received from the *Plan* agree to the same restrictions and conditions that apply to the City with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI or his or her duly appointed personal representative;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the City unless authorized by an individual;
- report to the *Plan* (i) any security incident as defined under the HIPAA Security Rule, and (ii) any Breach of Unsecured Protected Health Information; provided, however, that to avoid unnecessary burden on either party, the City shall report to the *Plan* any unsuccessful security incidents of which it becomes aware of only upon request of the *Plan*. The frequency, content and the format of the report of unsuccessful security incidents shall be mutually agreed upon by the parties. The term "unsuccessful security incidents" mean security incidents that do not result in unauthorized access, use, disclosure, modification or destruction of electronic PHI;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;

- make internal practices, books and records relating to the use and disclosure of PHI received from the *Plan* available to the HHS Secretary for the purposes of determining the *Plan*'s compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the *Plan* that the City still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made. Where the return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible.

Adequate Separation Between the Plan and the City Must Be Maintained
In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- Privacy Officer.
- Designee(s) of the Privacy Officer.
- Designated members of the Employee Benefits, Payroll and Accounting Departments.
- Designated members of the Information Technology Department.

The persons described in this section may only have access to and use and disclose PHI for the purposes described above.

If the persons described in this section do not comply with this plan document, the City shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.