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Summary Plan Description

Jackson County

Employee Health Care Plan

Dental Expense Coverage

This booklet is your Summary Plan Description (SPD) for dental coverage. Its purpose is to summarize the provisions of the Health Care Plan, which provide and/or affect payment or reimbursement for dental expenses. This SPD supersedes any and all SPDs previously issued to you by Jackson County. The Jackson County Health Care Plan Document and any enacted amendments take precedence over this booklet.

The purpose of providing a dental plan is to help you and your family defray the cost of necessary dental care and treatment.

The Plan is funded by Jackson County and employee contributions. The benefits and principal provisions of the group plan are described in this booklet. They are in effect only if you are eligible for the coverage, become covered, and remain covered in accordance with the provisions of the group plan.

All benefits described herein are being provided and maintained for you and your covered dependents by Jackson County, hereinafter referred to as the "County." Self Insured Services Company processes all benefit payments.

Claims processor:

Self Insured Services Company (SISCO)
P. O. Box 389
Dubuque, Iowa 52004-0389
(563) 583-7344 / (800) 457-4726
www.siscobenefits.com
sisco.service@siscobenefits.com

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Plan Description

Purpose

The Plan Document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by Jackson County (the "County") and referred to as the "Plan." The Plan Document explains the times when the Plan will pay or reimburse all or a portion of Eligible Expenses.

Effective Date of Plan	July 1, 2017
Name of Plan	Jackson County Health Care Plan
Name and Address of Plan Sponsor	Jackson County 201 W Platt St Maquoketa, Iowa 52060 (563) 652-3144
Name and Address of Claims Administrator	Self Insured Services Company (SISCO) P.O. Box 389 Dubuque, IA 52004-0389 (888) 242-9428 www.siscobenefits.com sisco.service@siscobenefits.com
Employer I.D. Number	42-6004923
Plan Number	501
Type of Plan	A self-funded group health plan providing dental expense coverage.
Agent For Legal Service	Jackson County
Funding of the Plan	Jackson County and Employee and Retiree Contributions, if required
Medium For Providing Benefits	The benefits are administered in accordance with the Plan Document by the Claims Administrator.
Fiscal Year of the Plan	Begins July 1 and ends June 30

Named Fiduciary and Plan Administrator

The Named Fiduciary and Plan Administrator is Jackson County, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan. The decision of the Plan Administrator will be final and binding on all interested parties.

Claims Processor is Not a Fiduciary

A Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Legal Entity

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

Contributions to the Plan

The amount of contributions to the Plan are to be made on the following basis:

The County will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the County and the amount to be contributed (if any) by each covered Employee. Notwithstanding any other provision of the Plan, the County's obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the County's obligation with respect to such payments. In the event that the County terminates the Plan, then as of the effective date of termination, the County and Covered Individuals will have no further obligation to make additional contributions to the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the County may modify, amend, or discontinue the Plan without the consent of or notice to Covered Individuals. Any changes made shall be binding on each Employee and on any other Covered Individuals. This right to make amendments shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The County reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the County will continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan Is Not a Contract

The Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the County the right to be retained in the service of the County or to interfere with the right of the County to discharge or otherwise terminate the employment of any Employee.

Claim Procedure

In accordance with applicable law, the County will provide adequate notice in writing to any Covered Individuals whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Covered Individuals. Further, the County will afford a reasonable opportunity to any Covered Individuals, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the County for that purpose.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the County finds that such an attempt has been made with respect to any payment due or to become due to any Covered Individual, the County in its sole discretion may terminate the interest of such Covered Individual or former Covered Individual in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Individual or former Covered Individual, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Individual or former Covered Individual, as the County may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment. This Provision does not prohibit a Covered Individual from assigning his benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided in ERISA, no director, officer, or Employee of the County or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the County from and against any such personal liability, including all expenses reasonably incurred in his defense if the County fails to provide such defense. The County and the Plan may each purchase fiduciary liability insurance consistent with applicable law.

Compliance

It is the intent of this Plan to comply with all federal regulations that govern health care including TEFRA (Tax Equity Fiscal Responsibility Act of 1982), DEFRA (the Deficit Reduction Act of 1984), COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). HIPAA (Health Insurance Portability and Accountability Act of 1996), and PPACA (Patient Protection and Affordable Care Act of 2010 also referred to as ACA - Affordable Care Act).

Eligibility Provisions

Eligible Class

All Full-Time active Employees who are normally scheduled to work for the County at least 30 hours per week on a regular basis and are on the regular payroll of the County for that work; all Part-Time active Employees who are normally scheduled to work for the County at least 20 hours per week on a regular basis and are on the regular payroll of the County for that work; and Eligible Retired Employees and former Employee's spouses as defined by the Plan. Temporary and contracted Employees are not eligible.

Required Period of Service

An Employee will be eligible for coverage on the first of the month following completion of 30 days of continuous Active Work.

Contribution

The Plan may be evaluated from time to time to determine the amount of Employee contribution (if any) required.

Changes in Eligibility

You should report any change in eligibility to your employer as soon as possible. Changes in eligibility include, but are not limited to:

- Marriage or divorce
- Death of a Dependent
- Birth or adoption of a child
- Dependent child reaching the limiting age

Dental Expense Benefits

Schedule of Benefits

Benefits are based on a Calendar Year - January 1 through December 31

Annual Individual Deductible	$25
Annual Family Deductible	$75
Benefit Percentage for Dental Expenses	
Class I (Diagnostic and Preventive Services)	80%, no Deductible required
Class II (Basic Restorative Services)	80% after the Annual Deductible
Class III (Major Restorative Services)	50% after the Annual Deductible
Class IV (Orthodontia)	50%, no Deductible required
Maximum Annual Benefit per Individual Classes I, II & III Combined	$1,000 per Covered Individual per Calendar Year
Maximum Annual Benefit per family Classes I, II & III Combined	$2,000 per Covered family per Calendar Year
Maximum Lifetime Benefit per Individual Class IV	$1,500 per Covered Individual

Comprehensive Dental Expense Benefits

Subject to the General Limitations section of this Plan and the limitations of this section, Usual, Customary and Reasonable charges incurred for the following Covered Dental Expenses will be covered in accordance with the percentage of coverage, Deductible amounts and maximums in the Plan Summary.

A pre-treatment review is recommended on all charges that will result in a payment of $250 or more unless it can be shown that treatment was made on an emergency basis.

The Deductible

The Deductible is the amount of Covered Dental Expenses which must be paid each Calendar Year before Comprehensive Dental Expense Benefits are payable. The amount of the Deductible is shown in the Plan Summary. Each Family member is subject to the Deductible up to the Family maximum as shown in the Plan Summary.

Dental Eligible Expenses

The term "Dental Eligible Expenses" means the expenses incurred by or on behalf of a Covered Individual for charges made by a Dentist for the performance of dental service provided for in the Plan Summary when the dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth, and begins while the Covered Individual is covered for Dental Benefits.

If the actual performance of a dental service begins on a date other than the date the service was recommended or determined to be necessary, the dental service will be considered to begin on the date the actual performance of the service begins. For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. All other expenses are considered incurred at the time a service is rendered or a supply furnished. Covered Dental Expenses do not include any expenses that are in excess of the Usual, Customary and Reasonable amount.

If a condition is being treated for which different treatments are suitable, the benefits under this Plan will be based on the service that, according to a determination made by the Plan Administrator, would produce a professionally satisfactory result.

Class I - Diagnostic & Preventive Services

1. **Dental X-rays.** Charges for dental x-rays:
    a. Full mouth (single or multiple films), but not more than once every three (3) years;
    b. Bitewing x-rays, but not more than once every twelve (12) months.
    c. Periapical x-rays (PAS)
    d. Any x-rays needed to diagnose a condition requiring treatment.
2. **Emergency Palliative Treatment.** Charges for emergency palliative treatment for pain.
3. **Fluoride.** Charges for fluoride applied to the teeth, but not more than once per Calendar Year; limited to Dependent children under age 14.
4. **Oral Examinations and Routine Cleaning (Prophylaxis).** Charges for oral examinations and routine cleaning (prophylaxis) of teeth; limited to one (1) per Covered Individual each six (6) months.

5. **Sealants.** Charges for sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 15, once per tooth.

6. **Space Maintainers.** Charges for space maintainers for covered Dependent children under age 14 limited to one (1) per tooth per calendar year.

Class II - Basic Restorative Services

1. **Anesthesia.** Charges for general anesthesia in connection with a covered procedure.

2. **Antibiotics.** Charges for injectable antibiotics.

3. **Consultations.** Consultations with a specialist.

4. **Endodontics.** Charges for endodontics.

5. **Extraction of Teeth.** Charges for extraction of teeth, including pre- and post-operative care, general anesthesia, local anesthetic and injectable antibiotics.

6. **Fillings.** Charges for regular cavity fillings, including amalgam, synthetic porcelains, composite and plastic fillings and stainless steel restorations. If you choose tooth-colored (composite) fillings to restore back teeth, benefits will be limited to the amount paid for a silver filling, and the difference will be patient responsibility.

7. **Fractures and Dislocations.** Treatment of fractures and dislocations.

8. **Oral Surgery.** Charges for oral surgery, including pre- and post-operative care, general anesthesia, local anesthetic and injectable antibiotics.

9. **Periodontics.** Charges for Periodontics

10. **Recementing.** Charges for recementing of bridges, crowns, or inlays.

11. **Relining.** Relining of full or partial dentures if done more than one (1) year after initial installation.

Class III - Major Restorative Services

1. **Crowns.** Crowns and gold fillings necessary to restore the structure of teeth broken down by decay/injury (charge for a crown or gold filling is limited to the charge for a silver, porcelain or other filling material unless the tooth cannot be restored with such materials); covered only if the crown or gold filling is over five (5) years old.

2. **Dentures/Fixed Bridgework.** Charges for replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if the existing denture or bridgework was installed at least five (5) years prior to its replacement and cannot currently be made serviceable.

3. **Gold Restorations**. Charges for gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

4. **Implants**. Implants for crowns, bridgework and dentures when member meets criteria (limitation: one (1) per tooth every 84 months).

5. **Orthognathic Surgery.** Charges to correct malpositions in the bones of the jaw.

6. **Repairs**. Charges for repair of crowns, bridgework and removable dentures.

Class IV – Orthodontics

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. These services include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance. Removable progression appliances (a.k.a., Invisalign braces) will be considered the same as traditional adjustable appliances by this Plan. The Plan will not pay for orthodontic charges incurred prior to the effective date of a Covered Individual's coverage under this Plan. Payment for orthodontic treatment which is started prior to the effective date of coverage will be limited to charges determined to be incurred while the Covered Individual is covered by this Plan.

Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on common dental standards, the Claims Administrator will determine the dental services on which payment is based and the expenses that will be included as Eligible Expenses.

Limitations

1. **Administration Fees.** Completion of claim forms or forms necessary for return to work or school, for providing dental records, or for broken or missed appointments.
2. **Anesthesiologists**. Charges billed by anesthesiologists.
3. **Congenital Deformities.** Charges for services or supplies to correct congenital deformities, such as a cleft palate.
4. **Cosmetic.** Charges for services or supplies which have the primary purpose of improving the appearance of the teeth, rather than restoring or improving dental form or function. Some examples include: laminate and veneers.
5. **Crowns.**
    a. Charges for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
    b. Charges for porcelain veneered crowns or pontics in excess of acrylic veneer crowns or pontics.
6. **Duplicate.** Charges for duplicate prosthetic devices or other dental applications.
7. **Employer's Liability Law.** Charges for services or supplies which are covered by any employer's liability laws.
8. **Excess Charges/Not Dentally Necessary.** Charges incurred in connection with services and supplies which are not Medically or Dentally Necessary or are in excess of Usual, Customary and Reasonable charges.
9. **Experimental.** Charges for Experimental procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association, the American Dental Association, the American College of Surgeons, and/or the United States Food & Drug Administration.
10. **Facings.** Charges for facings on pontics or crowns posterior to the second bicuspid.
11. **Government Hospital.** Charges for services and supplies provided by a U.S. Government hospital.

12. **Government Program.** Charges for services or supplies that you are entitled to claim from any governmental program even if you waived or failed to claim rights to such services, benefits, or damages.
13. **Hygiene.** Charges for oral hygiene, dietary instruction or plaque control programs.
14. **Infection Control.** Charges for infection control procedures (sepsis control - rubber gloves, gowns, etc.) when billed separately from actual dental treatment.
15. **Maximum Benefit.** Charges in excess of the maximums listed in the Schedule of Benefits.
16. **Medical Plan.** Charges for services which are covered under a medical plan sponsored by the County will not be coordinated with the Dental benefits provided by the County.
17. **No Obligation to Pay.** Charges for which the Covered Individual is not (in the absence of this Plan coverage) legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this Plan coverage.
18. **Occlusal Analysis.** Occlusal analysis, occlusal adjustments, mouth guards or occlusal guards, or any similar item.
19. **Personalization.** Personalization of dentures.
20. **Prescription Drugs.** Charges for Prescription drugs.
21. **Prior to Effective Date/After Termination Date.** Expenses incurred prior to the effective date of coverage under the Plan or after coverage is terminated.
22. **Relative.** Charges for services or supplies provided by a Dentist who is a Close Relative.
23. **Repair or Replacement.** Charges for repair or replacement of any orthodontic appliance.
24. **Retreatment.** Retreatment or additional treatment necessary to correct results of a previous treatment.
25. **Splinting.** Charges for services or supplies for crowns placed for the primary purpose of periodontal splinting, altering vertical dimension, or restoring the closing of the upper and lower teeth (occlusion).
26. **Teeth lost prior to the effective date of coverage.**
    a. Charges for the initial placement of a complete or partial denture or fixed bridgework if it involves replacement of one (1) or more natural teeth missing or lost prior to the effective date of coverage.
    b. Charges for dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth).
27. **Temporomandibular Joint Disorder (TMJ)**. Charges related to TMJ (temporomandibular joint disorder).
28. **Veneers.** Charges for veneers.
29. **War.** Any loss that is due to declared or undeclared act of war.
30. **Workers' Compensation.** Charges for any service or supply that could have been compensated under workers' compensation laws, including any services or supplies applied toward the satisfaction of any Deductible under your employer's workers' compensation coverage.

Eligibility for Coverage

Employee Eligibility and Effective Date

An Employee is eligible for coverage under the Plan when the Employee:

1. Is employed by the County on a regular, Part-Time Work or Full-Time Work basis as specified in the Plan Summary;
2. Is Actively at Work;
3. Has satisfied the Required Period of Service as specified in the Plan Summary; and
4. Is within the classification (if any) shown in the Plan Summary.

If the Employee has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan.

If the Employee meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be the day indicated in the Eligibility Provisions.

All Employee Coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such Employee is able to be actively at work at such time. If the Employee is not Actively at Work on the date this Employee Coverage would otherwise take effect, but would have been able to be Actively at Work at 12:01 A.M. Standard Time had such work commenced at that time, such Employee shall be eligible for coverage on that date. If an eligible Employee is not able to be Actively at Work on the date this Employee Coverage would otherwise become effective, his coverage shall become effective on the day he returns to Active Work except as required by HIPAA.

A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

If two (2) Employees (the mother and father of the child(ren)) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

An Employee who chooses not to keep his coverage in effect during a period of an approved leave of absence which qualifies under the Family and Medical Leave Act will be eligible to enroll for the same type of coverage (single or Family) which was in effect at the time of the leave of absence immediately upon return to Full-Time Work.

Each Employee will become eligible for Dependent Coverage on the latest of the following:

1. The date he becomes eligible for Employee coverage.
2. The date on which he first acquires a Dependent.
3. The date he first comes within the classification (if any) for Dependent Coverage, as stated in the Plan Summary.

If both spouses, including a domestic partner, are employed by the County and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible dependents.

Dependent Eligibility and Effective Date

A Dependent will be considered eligible for coverage on the date the Employee becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan. Each Employee who makes such written request for Dependent Coverage on a form approved by the County, shall, subject to the further provisions of this section, become covered for Dependent Coverage as follows:

1. If the Employee makes such written request on or before the date he becomes eligible for Dependent Coverage, or within the time frame listed in "Employee Eligibility" to enroll, he shall become covered, with respect to those persons who are then his dependents, on the date he becomes covered for Employee Coverage.
2. A Newborn child of an Employee will be covered from the moment of birth providing Dependent Coverage is in effect at the time of birth. If Dependent Coverage is not in effect, the Employee will have 31 days from the date of the birth to make application for Dependent Coverage and coverage will be retroactive to the date of the birth.
3. An adoptive child of an Employee or a child placed with the Employee for adoption will be covered from the date the child is placed in the physical custody of the Employee and the Employee is legally responsible for medical expenses incurred by said child if proper enrollment is completed within 31 days of the placement.
4. If a Dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new Dependent will be effective on the date of such court order, decree, or marriage if Dependent Coverage is in effect under the Plan at that time and proper enrollment is completed within 31 days of the event. If the Employee does not have Dependent Coverage in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new Dependent within the 31 day period immediately following the date of the court order, decree, or marriage, Dependent Coverage will be effective as required by HIPAA special enrollment provisions.

Domestic Partner Eligibility

A qualified domestic partner, as defined below, is eligible to apply for coverage under the Health Care Plan.

To be eligible for coverage as a domestic partner, the Participant and the domestic partner must complete and file with the Human Resource/Benefits department an "Affidavit of Domestic Partnership" in which they attest that:

A. They are each other's sole domestic partner, and responsible for each other's common welfare;
B. Neither party is married;
C. The partners are not related by blood closer than would bar marriage in the state in which they reside.
D. Each partner is at least eighteen (18) years of age; and
E. Three of the following conditions exist for the partners:
    1. The partners have been residing together for at least twelve (12) months prior to filing the "Affidavit of Domestic Partnership".
    2. The partners have common or joint ownership of a residence (home, condominium, or mobile home).
    3. The partners have at least two (2) of the following arrangements:
        a. Joint ownership of a motor vehicle

b. A joint credit card account
c. A joint checking account
d. A lease for a residence identifying both domestic partners as tenants

4. The domestic partner:
    a. Has been designated as a beneficiary of the participants Group Life Insurance
    b. Has been designated as a beneficiary for the death benefit payable from the employee's retirement, or
    c. The participant declares that the domestic partner is identified as a primary beneficiary in the Participant's will.
5. The domestic partners have executed a "relationship contract" which:
    a. Obligates each of the parties to provide support for the other party
    b. Provides, in the event of the termination of the domestic partnership, for a substantially equal division of any property acquired during the relationship.

Additional Provisions:

1. Notification of Changes. The parties must agree to notify the Human Resource /Benefits department of any changes in the circumstances which have been attested to in the documents qualifying a person for coverage as a domestic partner.
2. Liability for False Statements. If any County suffers a loss because of a false statement contained in the documents submitted in connection with coverage for a domestic partner or as a consequence of the failure to notify the HR/Benefits department of a changed circumstance, the County will be entitled to recover reasonable attorney fees in addition to damages for all such losses.
3. Termination. – Either member of a domestic partnership may file a statement with the Human Resource /Benefits department indicating the relationship has ended. A copy of the termination will be mailed to the other partner unless both have signed the termination statement.
4. Waiting Period. Following the termination of a domestic partnership, a twelve (12) month period must elapse before a Participant is eligible to designate a new domestic partner.

Retiree Eligibility

The County Board of Supervisors shall allow Eligible Retired Employees, and the former Employee's spouse, who retired before attaining 65 years of age to continue participation in the group plan or under the group's contract at the Employee's own expense until the former Employee attains 65 years of age.

Annual Enrollment Period

During the Annual enrollment period, which is commonly referred to as open enrollment, an Employee may change his or her election of benefits offered by the County for the ensuing benefit year. Changes include electing or terminating coverage under the Plan or changing coverage from one Plan to another, if more than one plan is offered. An Employee is only allowed to make these changes during the Annual enrollment period unless a qualifying event occurs, as required by HIPAA or as defined under Section 125.

Late Enrollment

Enrollment for coverage is required within 31 days after the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered Employee's and/or Dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a late enrollee. Some late enrollments may be made under the following Special Enrollment provision, however, if the Special Enrollment provisions do not apply, a late enrollee will only be eligible to enroll during the Annual enrollment period designated by the County.

Elections made during the Annual enrollment period will remain in effect until the first day of the following Plan Year unless a Covered Individual experiences an event that qualifies as a Special Enrollment event as defined below, or an event that allows the Covered Individual to change their election under a Section 125 plan.

Special Enrollment

Special enrollment rights may be triggered upon the occurrence of certain types of events as indicated below. When a triggering event occurs, an eligible individual who does not request enrollment in the Plan within the deadlines explained below, will lose special enrollment rights for that event.

1. **First Type of Event – Loss of Other Health Coverage**

   Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, which they stated in writing was in place, are entitled to enroll in the plan when the other coverage ends. This type of event also triggers an opportunity for an Employee who is enrolled in a Company sponsored Plan to switch to another Company sponsored Plan, if the Company has multiple Plans available.

   Other Coverage is COBRA Coverage. If the other coverage is COBRA coverage, the eligible Employee or Dependent must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.

   Other Coverage is Not COBRA Coverage. If the other coverage is not COBRA coverage, the Employee or Dependent must lose the other coverage as a result of loss of eligibility for the coverage, termination of employment, or termination of the employer contribution toward the other coverage. If an individual loses coverage due to ceasing to make required premium payments when due, he will not qualify as a special enrollee.

   Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 31 days after the loss of the other coverage or the termination of employer contributions toward that other coverage. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

   Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

2. **Second Type of Event – Addition of a Dependent**

An eligible Employee's marriage, or the birth, adoption or placement for adoption of his or her child, triggers special enrollment rights. This type of event also triggers an opportunity for an Employee who is enrolled in a Company sponsored Plan to switch to another Company sponsored Plan, if the Company has multiple Plans available.

Non-Participating Employee May Also Enroll. The addition of a new Dependent triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible Employee's child, the eligible Employee (assuming that he or she did not previously enroll), his or her spouse, and his or her Newborn child may all enroll because of the child's birth. The same rule applies to the eligible Employee's marriage or adoption of a child or a child's placement for adoption if the eligible Employee had not previously enrolled in the Plan.

Deadline for Special Enrollment Period. An eligible Employee must request special enrollment within 31 days of marriage, or birth, adoption or placement for adoption of his or her child. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.

Effective Date of Enrollment. The date of enrollment for coverage will be the date of the event in the case of birth, adoption or placement for adoption and not later than the first day of the first calendar month after the marriage occurs, and provided the Plan Administrator receives the enrollment form.

3. Third Type of Event – Loss of Medicaid or CHIP Coverage

Eligible Employees and their eligible Dependents whose Medicaid or CHIP (Children's Health Insurance Program) coverage terminates due to loss of eligibility are entitled to enroll in the Plan when the Medicaid/CHIP coverage ends.

Eligibility for Premium Assistance Subsidy Under Medicaid or CHIP. Eligible Employees and their Dependents, who become eligible for a premium assistance subsidy under Medicaid or CHIP, are entitled to enroll in the Plan when they become eligible for the premium assistance subsidy.

Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 60 days after the loss of Medicaid/CHIP coverage or becoming eligible for the premium assistance subsidy. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

Effect of Re-Enrollment on Deductibles and Benefit Limitations

Annual Deductibles and Benefit Limitations for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan within the same Calendar Year as termination occurs will be calculated and accrued as if no termination occurred.

The Maximum Annual Benefit for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan will be calculated and accrued as if no termination occurred, regardless of the number of times a Covered Individual terminates coverage and re-enrolls under this Plan.

Termination of Coverage

Employee Termination

Employee Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The last day of the month in which the Employee terminates employment.
2. The last day of the month in which the Employee ceases to be in a class of participants eligible for coverage.
3. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
4. The date the Plan is terminated; or with respect to any Employee benefit of the Plan, the date of termination of such benefit.
5. The date the Employee enters military duty.
6. The date of the Employee's death.

Dependent Termination

Dependent Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan.
2. The date of termination of the Employee's coverage under the Plan.
3. The date the Employee ceases to be in a class of participants eligible for Dependent Coverage.
4. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit.
6. The date the Dependent enters military duty.
7. The date the Dependent becomes covered under this Plan as an Employee.
8. The last day of the month in which the Employee's death occurs.

Extension of Benefits

Family and Medical Leave Act Provision

All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the County, Plan benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the County and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact the County.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

It is the intent of the Plan to adhere to the continuation of coverage provisions of The Uniformed Services Employment and Reemployment Rights Act (USERRA) effective October 14, 1994. Any Plan provisions which conflict with USERRA are superseded by USERRA. An individual who would like complete information regarding his rights under USERRA should contact the Plan Administrator.

COBRA Extension of Benefits

The requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Plan. If Plan coverage is discontinued because of any of the qualifying events described below, eligible Covered Individuals may elect continuation coverage under the Plan according to the COBRA rules.

A. Qualifying Events

An Employee of the County covered by the Plan, has the right to choose this continuation coverage if such Employee loses group health coverage because of a reduction in such Employee's hours of employment or the termination of such Employee's employment (for reasons other than gross misconduct).

The spouse of an Employee covered by the Plan, has the right to choose continuation coverage if such spouse loses group health coverage under the plan for any of the following reasons:

1. The death of the covered Employee;
2. The termination of the covered Employee's employment (for reasons other than gross misconduct) or reduction in the covered Employee's hours of employment;
3. Divorce or legal separation from the covered Employee;
4. The covered Employee becomes entitled to Medicare; or
5. A proceeding in a case under Title 11, United States Code, with respect to the County from whose employment the covered employee retired.

In the case of a Dependent child of an Employee covered by the Plan, the Dependent child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. The death of the covered Employee;
2. The termination of the covered Employee's employment (for reasons other than gross misconduct) or reduction in the covered Employee's hours of employment;
3. The covered Employee's divorce or legal separation;

4. The covered Employee becomes entitled to Medicare;
5. The Dependent cease to be a "Dependent child" as defined under the Plan; or
6. A proceeding in a case under Title 11, United States Code, with respect to the County from whose employment the covered Employee retired.

B. Important Notice Requirements

Under the law, the Employee or an eligible Dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing Dependent status under the Plan within 60 days of the later of: 1) the date the qualifying event occurs; 2) the date coverage is lost; or 3) the date the beneficiary is notified – through the Summary Plan Description (SPD) or the general COBRA notice. Such notice must be in writing to the Director of Human Resources, and contain the name of the Covered Individuals affected by the event and the date and nature of the event. The County has the responsibility to notify the Plan Administrator of the Employee's death, termination, reduction in hours of employment or Medicare entitlement, no later than 30 days after the date the Employee loses coverage due to the qualifying event.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will ensure that the employee and the Employee's eligible covered Dependents are notified within 14 days of the right to choose continuation coverage. Under the law, the Employee and eligible covered Dependents have 60 days from the later of: the date the Employee or his eligible covered Dependent(s) would lose coverage because of one of the events described above or the date the Employee or his eligible covered Dependent(s) are advised by the Plan Administrator of the right to continue coverage, to inform the Plan Administrator that the Employee and/or the eligible covered Dependents want continuation coverage.

Notice to the Employee's eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any eligible covered Dependent children residing with the Employee's spouse. If the Employee or his eligible covered Dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost.

An eligible Employee may elect COBRA continuation coverage for an eligible child who is born to, or placed for adoption with such Employee while the Employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the employee has notified the Plan Administrator in writing within 30 days of the child's birth, adoption or placement for adoption.

C. Payment for Continuation Coverage

The Employee and his eligible covered Dependent(s) will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage, plus 2%. The contributions must be paid by a check made payable to the County.

Contribution amounts and benefits for continuation coverage are subject to change. The Employee will be notified of any changes in contribution amounts or benefits available under the Plan.

If the Employee or his eligible covered Dependent(s) elect continuation coverage after the qualifying event, then the Employee or his eligible covered Dependent(s) will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of the payment. There is no grace period for the initial contribution. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

Covered Individuals will not be billed for any contribution payments for continuation coverage. If any contribution payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Plan will terminate and will not be reinstated.

D. Length of Continuation Coverage

If the Employee and/or his eligible covered Dependents elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment or reduced work hours is 18 months.

If the Employee or his eligible covered Dependent is found by the Social Security Administration (SSA) to be eligible for Social Security disability benefits because of a disability that existed at some time during the first 60 days of this COBRA continuation coverage, then the disabled person and his eligible covered Dependents will be eligible to continue Plan coverage for up to 29 months (an additional 11 months). To be eligible for that additional time to continue Plan coverage, the disabled person must remain disabled and must notify the Plan Administrator of the Social Security determination, in writing, by supplying a copy of the SSI award letter within the initial 18-month period and within 60 days after the later of:

- The date of the Social Security disability determination;
- The date of the qualifying event;
- The date on which coverage is lost as a result of the qualifying event, and
- The date on which the beneficiary is informed (in the Summary Plan Description or general notice) about the obligation to provide the disability notice.

An increased cost of up to 150% of the cost of the Plan coverage may be required for those 11 extra months of continuation coverage. The disabled person must promptly notify the Plan Administrator of any SSA finding that he or she is no longer disabled.

If a second qualifying event occurs within the applicable 18- or 29-month period, the period to continue Plan coverage under COBRA may be extended for up to 36 months from the first qualifying event. For all other qualifying events, the maximum period to continue Plan coverage is 36 months.

E. Termination of Continuation Coverage

However, COBRA provides that this continuation coverage may be cut short for any of the following reasons:

1. The County no longer provides group health coverage to any of its Employees;
2. The premium for this continuation coverage is not paid on time;
3. The Employee or his eligible covered Dependent(s) become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition such individuals may have or contains a pre-existing condition exclusion that does not apply to such individuals because of the requirements of the Health Insurance Portability and Accountability Act of 1996;
4. The Employee or his eligible covered Dependent(s) become entitled to Medicare; or
5. The Employee or his eligible covered Dependent(s) elected to extend coverage for up to 29 months due to disability and there has been a final determination by the SSA that such individual is no longer disabled.

The Employee or his eligible covered Dependent(s) must inform the Plan Administrator within 30 days of the date of any final determination by the SSA that the person is no longer disabled.

F. General Information about Continuation Coverage

Continuation coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation coverage retroactively if the Employee or his Dependent(s) are determined to be ineligible for continuation coverage. The Plan Administrator intends to provide

continuation coverage only to the extent required by the law and will administer continuation coverage according to those requirements.

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

Coordination of Benefits

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Eligible Expenses. It applies when the Employee or any eligible Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Eligible Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

All benefits contained in the Plan are subject to this provision.

Definitions

The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Individuals in a group whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits.
    b. Hospital reimbursement-type plans which permit the Covered Individual to elect indemnity at the time of claims.
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (HMO).
5. Any coverage for students which is sponsored by or provided through a school or other educational institution.
6. Any coverage under a governmental program, and any coverage required or provided by any statute.
7. Group automobile insurance.
8. Individual automobile insurance coverage on an automobile leased or owned by the County.
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term "Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Individual for whom claim is made has been covered under this Plan.

Coordination Procedures

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of Eligible Expenses incurred during any Claim Determination Period with respect to a Covered Individual eligible for:

1. Benefits either as an insured person or participant or as a dependent under any other plan which has no provision similar in effect to this provision, or
2. Dependent benefits under this Plan for a Covered Individual who is also eligible for benefits:
    a. As an insured person or participant under any other plan, or
    b. As a Dependent covered under another group plan.
3. Benefits under this Plan for a Employee who is also eligible for benefits as an insured person or participant under any other plan and has been covered continuously for a longer period of time under such other plan, or
4. If an eligible Dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to copayment and/or Deductibles not covered under the HMO and Eligible Expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Dependent chose not to avail himself to the HMO participating provider.

Order of Benefit Determination

Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans.
2. The plan which covers the claimant as an Employee or named insured pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the claimant as a dependent.
3. If the claimant is a Dependent child of parents not separated or divorced, the plan of the parent whose birthday occurs first in the Calendar Year shall pay first. If the parents have the same birthday, the plan that covered the parent longer will pay first and the other plan will pay second. This rule also applies to unmarried parents who are living together. However, if the parents are divorced, or unmarried and not living together, then:
    a. The plan of the parent who by court order or decree is financially responsible for the children's medical costs is primary.
    b. If no decree exists, the plan of the parent who has custody pays first;
    c. The plan of any stepparent with whom the child lives pays second;
    d. The plan of the parent without custody pays third.

    If the specific terms of a court decree state that the parents have 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 for dependent children of parents not separated or divorced.

    For purposes of this sub-section, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

4. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
5. If the order set out above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will pay first.

The County has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent.
2. To require that the claimant provide the County with information on such other plans so that this provision may be implemented.
3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the County's opinion, to satisfy the terms of this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the County will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the County will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

Right To Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the County may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the County deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the County such information as may be necessary to implement this provision.

Coordination of Benefits with Medicare

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each Individual that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Benefits under this Plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an Employee, Dependent or other.

Third Party Recovery, Subrogation and Reimbursement

Statement of Purpose

Subrogation and reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and reimbursement recoveries are used to pay future claims incurred by Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

Payment Condition

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

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (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 certain circumstances, a Plan Participant(s) his or her attorney, and/or legal guardian of a minor or incapacitated individual may receive a recovery that exceeds the amount of the Plan's payments for past and/or present expenses for treatment of the Illness or Injury that is the subject of the recovery. In other situations, a Plan Participant(s) may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the Illness or Injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not provide benefits for any present or future expenses related to the Illness or Injury for which compensation was provided through a current or previous recovery. The Plan Participant(s) is required to submit full and complete documentation of any such recovery in order for the Plan to consider Eligible Expenses that exceed the recovery. To the extent a Plan Participant(s)'s recovery exceeds the amount of the Plan's lien, the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the Illness or Injury. In those situations following any recovery that exceeds the amount of the Plan's lien, the Plan Participant(s) will be solely responsible for payment of medical bills related to the Illness or Injury out of the remaining recovery.

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). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs)

associated with the Plan's attempt to recover such money. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

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

If the Plan Participant(s) retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Plan Participant(s)'s attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of recovery. The Plan will not pay the Plan Participant(s)'s attorneys' fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the Plan Participant(s)'s attorneys' fees and costs.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. As a possessor of a portion of the recovery, the Plan Participant(s)'s attorney holds the recovery as a constructive trustee and fiduciary and is obligated to tender the recovery immediately over to the Plan. A Plan Participant(s)'s attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Plan Participant(s) nor the attorney is the rightful owner of the portion of the recovery subject to the Plan's lien.

Time of Payment of Benefits

The Plan may withhold benefits until such time that liability is determined.

Subrogation

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

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim that any Plan Participant(s) may have against any Coverage and/or party causing the sickness 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 it 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 Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

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

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company; or,
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by any 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. If the Plan Participant(s)' 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, expressed written consent of the Plan.

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

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:

a) 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;
b) instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c) 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; and,
d) 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 his or her 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 attorney 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.

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:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company or
e) 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 Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of the 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 Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) 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;

b) to provide the Plan with pertinent information regarding the Illness, Injury, disease, disability, including accident reports, settlement information and any other requested additional information;

c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

f) to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

g) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage;

h) 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;

i) 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; and

j) 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 Plan Participant(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant's or 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 Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

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

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan as explained in the Plan Description section.

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.

Rights under ERISA

Your Rights

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are

successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Notice of Claim

Written notice of claim should be submitted to the Claims Administrator as soon as possible. All claims must be filed by within one (1) year of the event on which claim is based or payment will be denied. Written notice of claim given by or on behalf of the Covered Individual to the Claims Administrator, with information sufficient to identify the Covered Individual, will be considered notice.

Failure to furnish proof within the time provided in the Plan will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Claim Procedure

Following is a description of how the Plan processes claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different types of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding the procedure, please contact the Claims Administrator.

There are three types of health claims: urgent care claims, pre-service claims, and post-service claims. Most claims are post-service claims which means a claim for a Plan benefit that is a request for payment under the Plan for covered medical services already received by the claimant. An urgent care claim is one for medical care or treatment where an untimely determination may jeopardize the life or health of the claimant. A pre-service claim means any claim for a benefit under this Plan where the Plan requires advance approval for obtaining medical care.

In the case of a post-service claim, the Claims Administrator will process your claims no later than 30 days after receiving it. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information. You will be notified during the first 30 days of the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination.

If your post-service claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your claim be denied (in whole or in part), or if there is a reduction of benefits or charge amount, you (or your provider) may have your claim reviewed. To do so, a review must be requested within 180 days of the denial by writing to:

Patient Advocate
Self Insured Services Company
P.O. Box 389
Dubuque, IA 52004-0389

You should supply any additional pertinent documentation to support the appeal of the claim. Within 60 days after receipt of your request for review, you will receive a determination from the Claims Administrator.

For an urgent care claim, notification of benefit determination will be given within 72 hours after the Claims Administrator receives the claim. If there is insufficient information to make a determination, a request will be made for the additional information within 24 hours of receiving the claim. This request may be in writing or orally. The claimant will then have 48 hours to provide the missing information. After receiving the information or when 48 hours has passed, the Claims Administrator will respond orally or in writing as to the benefit determination. If an urgent care claim is denied, an appeal may be filed with the Plan Administrator within 180 days of the denial. This appeal may be orally or in writing. Upon receipt of the appeal, a claim determination must be made within 72 hours. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

You will receive notice of benefit determination for a pre-service care claim within 15 days of the Claims Administrator's receipt of the claim. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information, and you will be notified within five (5) days of receipt of the claim as to the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination. If your pre-service care claim is denied, you may file a written appeal within 180 days of the denial. Upon receipt of the appeal, the Claims Administrator will have 30 days to make a benefit determination.

If the Plan has previously approved an ongoing course of treatment for a participant to be conducted over a period of time, any reduction or termination of that course of treatment will be deemed to be an adverse benefit determination. The Plan Administrator must then notify the claimant a sufficient time in advance of the reduction or termination to give the claimant time to obtain a review on appeal of the adverse termination before the benefit is reduced or terminated.

Proof of Loss

The Plan Administrator will have the right and opportunity to have examined any individual whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Free Choice of Physician

The Covered Individual will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained.

Payment of Claims

All Plan benefits are payable to the provider of service, or subject to any written direction of the Employee. All or a portion of any payments provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Employee or if the participant is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee: spouse, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.

Assignment of Benefits

Assignment of Benefits occurs when the Covered Individual authorizes the Plan to pay benefits directly to the provider of services, in strict accordance with the terms of this Plan. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of the Covered Individual, and are limited by the terms 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.

Benefits may not be assigned except by consent of the Company, other than to Eligible Providers and according to the provisions set forth in the Plan Document.

Rights of Recovery

Whenever payments have been made by the County with respect to Eligible Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the County will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future benefits to offset for such excess payments. The Plan has the right to recover these amounts through any legal or equitable remedy, including imposition of a constructive trust.

Rescission, Termination, or Modification of Coverage

The Plan reserves the right to rescind coverage for any Covered Individual when 1) the Covered Individual (or a person seeking coverage on behalf of the Covered Individual) performs an act, practice or omission that constitutes fraud; or 2) the Covered Individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage.

The Plan shall provide at least thirty (30) days advance written notice to each Participant who would be affected by the proposed rescission of coverage before coverage under the Plan may be rescinded. The affected person has the right to appeal the decision.

Not all retroactive terminations of coverage are rescissions. Rescissions, for example, do not include retroactive cancellations of coverage for failure to pay required premiums or contributions toward the cost of coverage on time. A prospective cancellation of coverage is not a rescission.

A Covered Individual's coverage under the Plan may be terminated or modified by the Plan 1) if the Covered Individual commits acts of physical or verbal abuse that pose a threat to providers, health care workers, to those involved with the administration of the Plan, or to other Covered Individuals under the Plan; 2) if the Covered Individual allows a non-Covered Individual to use the Covered Individual's proof of coverage to obtain services; or 3) in lieu of rescission for the reasons as outlined above for rescinding coverage.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Legal Proceedings

No action at law or in equity will be brought to recover on the Plan until you have followed the Plan's claims procedures and exhausted the opportunities described under the Plan's claims procedures, nor will such action be brought at all unless brought within three (3) years of receiving the final review notice under the Plan's claims procedures.

Conformity with Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Permitted and Required Uses of Protected Health Information

Protected Health Information (PHI) is individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. PHI will only be released to the "Privacy Officials" appointed by the County. A list of Privacy Officials may be obtained from the County.

Your health Plan will only provide Protected Health Information to the Plan Sponsor upon receipt of certification that the Plan Sponsor will agree to:

1. Not use or disclose the PHI other than as permitted or required by the Plan Document or as required by law;
2. Ensure that agents and subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions as the Plan Sponsor;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the group health Plan any PHI use or disclosure, of which it becomes aware, that violates the permitted uses or disclosures under HIPAA;
5. Make PHI available in accordance with HIPAA privacy regulation, 45 CFR 164.524;
6. Make PHI available for amendment and incorporate those amendments as required by HIPAA privacy regulation, 45 CFR 164.526;
7. Make information available to provide an accounting of disclosures as provided in HIPAA privacy regulation, 45 CFR 164.528;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services;
9. If feasible, at termination of the relationship, return or destroy all PHI received from the group health plan, but if return or destruction is not feasible, limit further uses or disclosures to those purposes that make return or destruction of the information infeasible; and
10. Ensure adequate separation between Employees who are authorized to use PHI and those who are not.

Any information supplied to the Plan Sponsor in order to process claims and claim payment will be kept confidential by all individuals within the County who use this information in the normal course of business. These individuals will restrict access to and use of PHI by individuals other than for plan administration functions that the Plan Sponsor performs for the group health plan. Misuse or improper disclosure of PHI by any individual in the County will result in disciplinary sanctions, which may include dismissal. The County shall provide a mechanism for resolving issues of noncompliance. PHI will not be disclosed to a Plan Sponsor for employment-related activities or decisions or in connection with any other benefit plan of the Plan Sponsor.

HIPAA Security Provision

Where electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. sect. 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and
4. Plan Sponsor shall report to the Plan any "Security Incidents" of which it becomes aware as described below ("Security Incidents" has the meaning set forth in 45 C.F.R. sect. 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system):
    a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any "Security Incident" that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic Protected Health Information; and
    b) Plan Sponsor shall report to the Plan any other "Security Incident" on an aggregate basis every quarter, or more frequently upon the Plan's request.

Time Limitation

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted under the guidelines of ERISA and/or any federally mandated law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Statements

All statements made by the County or by a Covered Individual will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this Plan will be used in any contest to avoid or reduce the benefits provided by the Plan unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Individual.

Any Covered Individual who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Individual may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Miscellaneous

Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan.

Pronouns used in this Plan Document shall include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the County's right thereafter to enforce such provision, nor will such failure affect the County's right to enforce any other provision of this Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, the Plan, Plan Administrator, Agent for the Service of Legal Process, Trustee, Claims Administrator, and County will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

Payment for expenses in relation to services which are generally accepted as cost-containment measures in large claim management cases that are not normally covered under this Plan will be reimbursable upon recommendation of the Claims Administrator and written approval by the Plan Administrator.

Definitions

Accidental Injury

A condition which is the result of bodily Injury caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; this incident must be of a sufficient departure from the claimant's normal and ordinary lifestyle or routine; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

Active Work/Actively at Work

An Employee is considered to be at active work or actively at work when performing, in the customary manner, all of the regular duties of his occupation with the County. An Employee shall be deemed at active work or actively at work on each day of a regular paid vacation; or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day.

Amendment

A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator

Annual

Periodic, based on a Calendar Year.

Benefit Percentage

That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual Deductible, which are to be paid by the Employee.

Benefit Period

A time period of one Calendar Year. Such benefit period will terminate on the last day of the one-year period so established.

Calendar Year

A period of time commencing on January 1 and ending on December 31 of the same given year.

Claim Determination Period

A Calendar Year or that portion of a Calendar Year during which the individual for whom claim is made has been covered under this Plan.

Claims Processor

The person or firm employed by the County to provide consulting services to the County in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Close Relative

The spouse, parent, brother, sister, child, or spouse’s parent of the Covered Individual.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

That figure shown as a percentage in the Plan Summary used to compute the amount of benefit payable when the Plan states that a percentage is payable.

County

Jackson County.

Cosmetic Procedure

A procedure performed to:

- change the texture or appearance of the skin; or
- change the relative size or position of any part of the body;

when such surgery is performed primarily for psychological purposes or for improvement of appearance rather than for restoration or improvement of a bodily function.

Covered Individual

Any Employee or Dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

Deductible

A specified dollar amount of Eligible Expenses which must be incurred during a Benefit Period before any other Eligible Expenses can be considered for payment according to the applicable Benefit Percentage.

DEFRA

The Deficit Reduction Act of 1984, as amended.

Dentist

An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a Dentist when he performs any of the dental services described herein and is operating within the scope of his license.

Dependent

The term "Dependent" means:

A. The Employee's legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed.

B. The Employee's domestic partner as defined by the Plan.

C. Children up to age 26 as defined below.

1) Natural-born children.
2) Stepchildren as long as the child's legal parent remains married to the Employee.

3) Legally adopted children and children placed with you for adoption. Date of placement means the assumption and retention by a person of a legal obligation in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation.
4) Foster children who reside in the Employee's home.
5) Children of a domestic partner who reside in the Employee's home.
6) Children of a common law spouse who reside in the Employee's home.

D. Children who are required to be covered by reason of a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an Order qualifies as a QMCSO. You and your family members can obtain, without charge, a copy of such procedures from the Plan Administrator.

E. Children up to age 26 for whom the Employee or Employee's spouse has been named legal guardian whose primary residence is with the Employee and who depends upon the Employee for support and maintenance. The County will require proof of legal responsibility in order for them to become an eligible family member.

F. Disabled children age 26 and over if all of the following apply:
1) is a child as defined in point C above.
2) is unmarried.
3) became handicapped prior to reaching age 26.
4) is primarily dependent upon the Employee/Employee's spouse for support and maintenance.
5) is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders.
6) is enrolled in the plan on the child's 26th birthday.

To qualify for this disabled child coverage extension, the plan administrator must receive proof of the requirements above. After this initial proof, the plan administrator may request proof again two (2) years later, and each year thereafter.

Those situations specifically excluded from the definition of a Dependent are:

1. A Dependent who lives outside of the United States of America, unless the Dependent has established his or her primary residence with the Employee.
2. A spouse who is legally separated or divorced from the Employee, or in the case of a domestic partnership, the relationship is terminated and/or he or she no longer meets the eligibility requirements as defined in the plan.
3. A child who is married.
4. Any Dependent who is in active military services.
5. Any Dependent covered under this Plan as an individual Employee.
6. Any person who is covered as a Dependent by another Employee of the County.

Dependent Coverage

Eligibility under the terms of the Plan for benefits payable or Eligible Expenses of a Dependent.

Eligible Expense

Any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

Eligible Retired Employee

A former Employee of the government of the state of Iowa, including but not limited to any departments, agencies, boards, bureaus, or commissions of the state of Iowa, who is receiving the minimum level of retirement benefits under the retirement system established in chapter 97B, Iowa Code, and who was participating in Jackson County's group dental Plan which covers the former Employee and the former Employee's spouse at the time of retirement of the former Employee.

Emergency

An "Emergency" is defined as 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 1) a condition 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; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Employee

An active Employee of the County receiving compensation from the County for services rendered to the County. Employee means a person who is in an Employer-Employee relationship with the County and who is classified by the County as a regular Employee. The term "Employee" shall not include any individual classified by the County as an independent contractor, a consultant, an individual performing services for the County who has entered into an independent contractor or consultant agreement with the County (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common-law employee) or a leased employee as defined in Section 414(n) of the Code. The term Employee does not include any employee covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that health care benefits were the subject of good faith bargaining between the employee's bargaining representative and the County. The term Employee does not include an employee classified by the County as a temporary employee.

Employee Coverage

Eligibility under the terms of the Plan for benefits payable for Eligible Expenses of an Employee.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Expenses Incurred

The day supplies or services are rendered.

Experimental

Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of carrying out scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is experimental the County will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institute of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

Family

A Covered Employee and his eligible Dependents.

Full-Time Work

A basis whereby an active Employee is normally scheduled to work for the County for an average of at least 30 hours per week on a regular basis. Such work may occur either at the usual place of business of the County or at a location to which the business of the County requires the Employee to travel and for which he receives regular earnings from the County.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

HIPAA

The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Injury

The term "Injury" shall mean only accidental bodily Injury caused by an external force. All injuries to one person from one accident shall be considered an "Injury."

Lifetime

The term "lifetime," which is used in connection with benefit maximums and limitations, means the period during which the person is covered under the County Health Plan, whether or not coverage is continuous. Under no circumstances does "lifetime" mean during the lifetime of the Covered Individual.

Maximum Annual Benefit

The maximum benefit amount in the Schedule of Benefits.

Medically Necessary

The service a patient receives which is recommended by a Physician and is required to treat the symptoms of a certain Illness or Injury. Although the service may be prescribed by a Physician, it does not mean the service is Medically Necessary. The care or treatment 1) must be consistent with the diagnosis and prescribed course of treatment for the Covered Individual's condition; 2) must be required for reasons other than the convenience of the Covered Individual or the attending Physician; 3) is generally accepted as an appropriate form of care for the condition being treated; and 4) is likely to result in physical improvement of the patient's condition which is unlikely to ever occur if the treatment is not administered.

Medicare

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

Named Fiduciary

Jackson County, which has the authority to control and manage the operation and administration of the Plan.

Newborn

An infant from the date of birth until the mother is discharged from the Hospital.

Part-Time Work

A basis whereby an active Employee is normally scheduled to work for the County for an average of at least 20 hours per week on a regular basis. Such work may occur either at the usual place of business of the County or at a location to which the business of the County requires the Employee to travel and for which he receives regular earnings from the County.

Plan

The term "Plan" means without qualification the Plan outlined herein.

Plan Administrator

The County, which is responsible for the management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Plan Sponsor

Jackson County.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended from time to time.

Pre-Authorization

Pre-Authorization determines whether a proposed treatment is covered by the Health Plan. An Eligible Provider or a Covered Individual may submit information to the Claims Administrator regarding a proposed service to determine if and at what level the service is covered by the Plan.

Primary Plan

A plan whose allowable benefits are not reduced by those of another plan.

Pronouns

Any references to "You, Yours, or Yourself" means the eligible Employee and Covered Dependents. "He, His, Him" refers to either sex; not to be discriminatory, but to avoid "he/she" type wording.

Qualified Medical Child Support Order (QMCSO)

In order to meet the definition of a Qualified Medical Child Support Order (QMCSO), a court order or divorce decree must contain all of the following information:

1. The Employee's name and last known address.
2. The Dependent's full name and address.
3. A reasonable description of the coverage to be provided or the manner in which coverage will be established, i.e. through the employer.
4. The period for which coverage must be provided.

A National Medical Support notice, issued pursuant to ERISA section 609(a)(5)(C) and applicable regulations, will also meet the definition of a QMCSO.

Retiree/Retired Employee

An Employee of the County who has retired from active service with the County.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

TMJ

"TMJ" means temporomandibular joint syndrome and all related complications or conditions.

Total Disability (Totally Disabled)

A physical state of a Covered Individual resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
2. A Dependent from performing the normal activities of a person of like age and sex and in good health.

Usual, Customary and Reasonable (UCR)

The term "usual, customary, and reasonable" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a geographic area or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.