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Summary Plan Description

Jackson County

Partially Self-Funded Health Care Plan

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

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

All claims for medical benefits are submitted to the Jackson County fully insured group health plan first, after which remaining eligible medical expenses are then considered by this Plan.

The purpose of providing a comprehensive medical plan is to protect you and your family from serious financial difficulties resulting from necessary medical care. However, we all must recognize and deal with the rising cost of health care. Being informed about the specific provisions of your health plans, both the fully insured plan and this Plan, will help both you and Jackson County maintain reasonable rates in the future. We have prepared these pages as a guide for you to become familiar with your Plan and thereby an informed consumer of health care. It will take a cooperative effort among hospitals, physicians, you and us – Jackson County – to make our Plan work, now and in the future.

All health 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 for this Partially Self-Funded Plan.

Claims processor for the Partially Self-Funded Plan:

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
Type of Plan	A self-funded group health plan providing medical and prescription 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

Health plan benefits offered by Jackson County are provided through a fully insured plan with Wellmark Blue Cross & Blue Shield of Iowa. All medical claims are submitted to the fully insured plan before they may be submitted to this Plan. The County provides this self-funded plan that buys benefits down to the levels listed in this Plan. Claims under the self-funded plan are processed by Self Insured Services Company (SISCO). Amounts applied to the Deductible and Out-of-Pocket under the Wellmark plan will be considered Eligible Expenses under this Plan. For information regarding any specific issue that is not addressed in the document, refer to the Wellmark plan summary.

Named Fiduciary and Plan Administrator

The Named Fiduciary and Plan Administrator is Jackson County, which 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 is 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 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 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 or her 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 or her benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided by law, 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 or her defense if the County fails to provide such defense. The County and the Plan each may purchase fiduciary liability insurance consistent with applicable law.

Except as otherwise provided by law, 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 each may 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), PPACA (Patient Protection and Affordable Care Act of 2010 also referred to as ACA - Affordable Care Act), and any regulations that may become effective.

Plan Summary for Jackson County

Jackson County (the County and the Employer) offers this plan to eligible Employees in addition to its comprehensive medical benefit plan, a high deductible health plan hereinafter referred to as the Primary Plan. Conditions regarding eligibility for coverage, eligible medical expenses and exclusions are determined by the Primary Plan.

Eligibility and Effective Date of Participation

Any Eligible Employee or Retiree shall be eligible to participate in this Plan as of the date he or she satisfies the eligibility conditions for the Employer's Primary Plan.

An Eligible Employee or Retiree electing participation in this Plan shall become a Covered Individual effective as of the entry date under the Employer's Primary Plan.

Medical Expense Benefit Summary

All claims for medical benefits must be submitted to the Primary Plan first, after which remaining eligible medical expenses are considered by this Plan.

If other than single coverage is in place, each Covered Individual's responsibility will be limited to the Annual Individual Deductible and to the Annual Individual Out-of-Pocket Maximum amounts, as specified.

The In-Network and Out-of-Network Deductible and Coinsurance amounts track together. The In-Network and Out-of-Network Out-of-Pocket Maximum amounts track together.

Benefits follow a Calendar Year: January 1 – December 31

This Plan partially self funds eligible medical expenses so that the Annual Deductible and Out-of-Pocket Maximum end up being the amounts shown on the schedule below. All other medical benefits are paid by the Primary Plan (the fully insured plan with Wellmark).

	In-Network	**Out-of-Network**
Annual Deductible	Individual: $250 Family: $500	
Annual Out-of-Pocket Maximum including Deductibles and Coinsurance	Individual: $500 Family: $1,000	
Benefit Percentage In conjunction with the Primary Plan, the percentage paid toward Eligible Expenses after the Annual Deductible has been met	90% after the Annual Deductible	80% after the Annual Deductible

Comprehensive Medical Expense Benefits

Upon receipt of proof of loss, the Plan will pay the Benefit Percentage listed in the Plan Summary for Medically Necessary Eligible Expenses incurred in each Benefit Period.

The Deductible

The Deductible is the amount of Eligible Expenses which must be paid each Calendar Year before Medical 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.

Family Deductible

If the Family Deductible limit, as shown in the Plan Summary, is incurred by covered Family members during the Calendar Year, no further Deductibles will be required on any Family members for the rest of the Calendar Year; each Family member's responsibility will be limited to the individual Deductible as specified in the Summary of Benefits.

Out-of-Pocket Maximum

After the Annual Deductible is met, the Plan will pay the applicable percentages of Eligible Expenses as shown in the Schedule of Benefits. When the Out-of-Pocket maximum amounts are met, as stated in the Schedule of Benefits, the Plan will pay 100% of additional Eligible Expenses for the remainder of that Calendar Year, but not to exceed the point where the Primary Plan's out-of-pocket maximum is met, at which time that plan pays 100% of additional eligible expenses for the remainder of that Calendar Year.

Allocation and Apportionment of Benefits

The County reserves the right to allocate the Deductible amount to any Eligible Expenses and to apportion the benefits to the Covered Individual and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Individual and all assignees.

Medical Eligible Expenses

Medical Eligible Expenses are Medically Necessary expenses that are incurred while Plan coverage is in force for the Covered Individual. Medical expenses which are applied to the Covered Individual's Deductible and Out-of-Pocket Maximum under the Primary Plan are the only expenses that are eligible for coverage under this Plan. Refer to the plan summary of the Primary Plan for additional information concerning eligible expenses under that plan.

General Limitations

The following exclusions and limitations apply to expenses incurred by all Covered Individuals:

1. Expenses that are excluded or ineligible under the Primary Plan are excluded under this Plan.

Eligibility and Enrollment

An individual's eligibility for coverage under this Plan is based solely upon his or her eligibility under the Primary Plan. If an individual is not eligible for coverage under the Primary Plan, that individual is not eligible for coverage under this Plan.

An Employee and his or her eligible dependents are eligible for coverage under this Plan from the first day of eligibility for coverage under the Primary Plan.

An Employee who properly enrolls for coverage for himself or herself and any eligible dependents under the Primary Plan may also elect to be enrolled for coverage under this Plan with the same effective date as the Primary Plan.

An Employee who fails to properly enroll for coverage for himself or herself and any eligible dependents under the Primary Plan is not eligible for coverage under this Plan.

An Employee who chooses not to keep his or her 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 work.

Termination of Coverage

A Covered Individual's coverage under this Plan will terminate on the same date and time that his or her coverage under the Primary Plan terminates.

With regard to this Plan, the Covered Individual's participation in the Plan shall cease. However, such Covered Individual may submit claims for expenses incurred during the portion of the Plan Year preceding his or her date of termination.

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.

General Provisions

Notice of Claim

Written notice of claim should be submitted to the Claims Administrator as soon as possible. All claims must be filed within one (1) year of the event on which the 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 and Appeal Process

Following is a description of the time frames the Plan uses to process claims for benefits. A claim is defined as any request made by a claimant or by a representative of a claimant for a Plan benefit 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 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 are requests 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.

You have a right to appeal any decision made by the Plan that denies payment of your claims or your request for coverage of a health care service or treatment. You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Request for appeal/explanation should be sent to:

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

You should contact SISCO for any of the following reasons:

- You do not understand the reason for the denial;
- You do not understand why the health care service or treatment was not fully covered;
- You do not understand why a request for coverage of a health care service or treatment was denied;
- You cannot find the applicable provision in your Summary Plan Description;
- You want a copy of the guideline, criteria or clinical rationale that was used to make the decision; or
- You disagree with the denial or the amount not covered and you want to appeal.

If a claim is denied due to missing or incomplete information, you or your health care provider may resubmit the claim with the necessary information to complete the claim.

All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent in writing to the address above within 180 days of the date you receive the denial. A full and fair review of the claims will be provided by individuals who were not involved in making the initial decision of the claim. You may provide additional information that relates to the claim and you may request copies of information that pertain to your claims. You will be notified of the decision in writing within 60 days of the Plan receiving your appeal. If you do not receive a decision within 60 days, you may be entitled to file a request for external review.

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 based on the procedures stated above. 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 must be provided as soon as possible, taking into account any medical exigencies, but in no case later than 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 determination before the benefit is reduced or terminated.

If your request for the provision of or payment for a health care service or course of treatment has been denied, you may have a right to an external review by an Independent Review Organization (IRO), which has no association with the Plan, if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment. You may request the independent external appeal by submitting a request for external review within four (4) months after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. The external review process is not available for questions of eligibility or rescissions of coverage. Requests should be submitted to SISCO at the address listed above. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five (5) business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

(a) The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

(b) The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

(c) The claimant has exhausted the plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the plan must issue notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within a 48-hour period following the receipt of the notification, whichever is later.

The plan must assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Within five (5) business days after the date of assignment of the IRO, the plan will provide the IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one (1) business day after making the decision, the IRO will notify the claimant and the plan. The IRO must provide written notice of the final external review decision to the Plan and the Covered Individual within 45 days after the request for external review is received. All decisions made by the IRO will be binding on the Plan. If the IRO reverses an Adverse Benefit Determination, the Plan must immediately provide coverage or payment for the claim.

Expedited Review Process

If the normal time frames set out above for an external review would seriously jeopardize the life or health of a Covered Individual or would jeopardize the individual's ability to regain maximum function, an expedited external review may be requested. Upon receipt of request for an expedited external review, the Plan will immediately determine if the request meets the guidelines for an external appeal and assign an Independent Review Organization (IRO) to review the case. Information regarding the appeal will be sent to the IRO electronically or by telephone or facsimile or any other expeditious method. The assigned IRO will review the claim information and return a decision within 72 hours after receiving the request for review. If the IRO notice is not in writing, within 48 hours after the date of providing the decision, the IRO must provide written confirmation of the decision to the claimant and the Plan.

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 County, 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.

Claims Audit

The Plan Administrator shall have the right to review and audit all claims to ensure that the charges are Usual, Customary and Reasonable and Medically Necessary and payable in accordance with the terms and limitations of the Plan, and may reduce any reimbursement to the Maximum Allowable Charge, in accordance with the terms of the Plan. The Plan Administrator shall have the ability to select which claims are subject to audit. The Plan Administrator shall have the right to utilize an independent bill review and/or claim audit program or service.

Workers' Compensation Not Affected

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

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.

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 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 that 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

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 or her 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 or she was Actively at Work on the last preceding regular working day. As required by HIPAA, absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the Plan or coverage under the Plan, as being actively at work.

Adverse Benefit Determination

An adverse benefit means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. Refer to the "Claim Procedure and Appeal Process" in the "General Provisions" section of this document.

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.

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.

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.

Dependent

The term "Dependent" means the Employee's legal spouse and dependent child(ren), and any others as defined and accepted by the Primary Plan. At any time, the Plan may require proof that an individual qualifies or continues to qualify as a dependent as defined by this Plan.

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.

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 contract 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 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.

Family

A Covered Employee and his or her eligible Dependents.

Final Internal Adverse Benefit Determination

A final internal adverse benefit determination means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process. Refer to the "Claim Procedure and Appeal Process" in the "General Provisions" section of this document.

Full-Time Work

A basis whereby an Employee works 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 or she receives regular earnings from the County.

HIPAA

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

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.

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.

Primary Plan

As used in this document, the Primary Plan is the Employer's comprehensive medical benefit plan and in which the Covered Individual is enrolled in order to be eligible for coverage under this Plan. All claims must be submitted to the Primary Plan first before they may be considered under this Plan.

Pronouns

References to *you*, *your*, and *yourself* refer to the eligible Employee and Covered Dependents. References to *he*, *his*, or *him*, where they may still occur, may refer to either gender; these references are not meant to be discriminatory, but to avoid "he or she" type wording, as was custom.

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

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