VERNON COUNTY

Missouri

HEALTH CARE PLAN

Summary Plan and Plan Description effective 12-1-21

PLAN SPONSOR / PLAN ADMINISTRATOR / AGENT FOR LEGAL PROCESS: Vernon County Courthouse, 100 W Cherry, Suite 6, Nevada, MO 64772-3367. Phone 417-448-2500. **TIN:** 44-6000613 **END OF PLAN YEAR:** November 30 **PLAN #:** 501. **TYPE OF PLAN:** Welfare plan for payment of health care expenses as defined herein. **CLAIM ADMINISTRATOR:** Mutual Medical Plans, Inc., 416 Main St., Suite 1025, Peoria, IL 61602. (309) 674-0888 or (800) 448-4689. **AMENDMENTS:** The plan sponsor reserves the right to amend or discontinue the plan. **CONTRIBUTIONS:** You contribute to the Plan in amounts determined by the plan sponsor. The balance of cost is paid by the plan sponsor.

ELIGIBILITY: You and your dependents become eligible on the first of the month following 60 days of employment as a full time employee (30 or more hours per week). You must apply by the date you become eligible. If you do not apply when first eligible or if you decline coverage, you may enroll at a future date if due to loss of other coverage, marriage, divorce, birth, adoption or placement for adoption provided that you apply within 30 days of the event. Coverage will become effective on the first of the month after your timely request for enrollment due to marriage or loss of other coverage. If the other coverage was COBRA, the COBRA must be exhausted. Non-payment of premium is not considered loss of other coverage. For birth, adoption or placement for adoption, coverage becomes effective on the date of the event, or later if agreed to by you and the Plan Sponsor, assuming you made a timely request for coverage. A person eligible for this Plan may enroll within 60 days of the eligibility date, termination date, or premium assistance date of Medicaid, Mo Health Net, or CHIP. If you do not enter the Plan under the above provisions, you will not be able to enroll in the Plan unless a special enrollment is held by the Plan Sponsor. If you have another health plan that penalizes you or your spouse if you do not enroll in this Plan, then you will not be eligible for this Plan unless an exception is made by the Plan Sponsor.

TERMINATION: Coverage will be terminated: 1) on the last day of the month in which you resign or terminate employment, 2) when any required contributions are not made, 3) the date a dependent is no longer eligible, 4) the date you have exhausted FMLA leave and/or applicable benefit time defined as vacation, compensatory time, or sick leave, or 5) when the Plan Administrator determines it is in the best financial interest of the plan member.

DEFINITIONS:

"You" and "employee" means an employee or elected official of Vernon County.

“Dependent” means your lawful spouse who resides with you in common residence and your under age 26 natural child, adopted child, child placed with you for adoption, or stepchild that you or your spouse have legal guardianship or legal custody or had such guardianship or custody when the child turned age 18, without regard to residence, financial support, or marriage.

"Hospital" means an institution providing care for the sick under supervision of a staff of physicians and nurses on a 24 hour basis. It does not include health resorts or nursing homes, skilled nursing homes, step down units, or long term care facilities, but it does include a state licensed surgery center or a substance abuse treatment center that has an agreement with the Plan or claim administrator..

"Physician" means a duly licensed M.D., D.O., O.D., D.P.M., D.D.S., D.C., Certified Physician’s Assistant, Midwife, Nurse Practitioner, or R.N., and in the case of outpatient mental care, a clinical psychologist, regional mental health center, L.C.S.W., or L.C.P.C. A nurse practitioner will be covered for an office visit as a nurse visit code 99211, however billed, and for lab work only when approved by the Claim Administrator.

"Reasonable and customary" means the fee most commonly charged for a service by other health care providers, as determined by the Plan. “Maximum Allowable Charge” means an amount determined by the Plan to be appropriate for the services rendered, usually at 200% of Medicare allowances.

COORDINATION OF BENEFITS

Pursuant to Missouri laws V.A.M.S 476.433, 208.215 and 20CSR400-2.030(2)4F which bestows the same rights on public groups that Medicaid has in regard to paying secondary, this Plan is the payor of last resort and secondary to other health care plans, insurance company policies either individual or group, and other sources of payment, except where contrary to applicable law.

MAJOR MEDICAL 2,700

After a calendar year deductible of $2,700 per person ($5,400 family) and subject to co-pays as listed below, the Plan pays for 80% of covered charges for PPO participating providers (as indicated on your ID card) and 50% of maximum allowable charges for Non-PPO. The out of pocket limit, including the deductible, is $5,400 per person and $10,800 family for expenses incurred in a calendar year. There is no coinsurance out-of-pocket expense limit for charges paid at 50%, non-covered services, amounts over reasonable and customary or amounts over the maximum allowable charge. Subject to the limitations and exclusions, covered charges are as follows for expenses related to an illness or injury.

1. Hospital room and board charges up to the hospital's semi-private rate; charges for intensive care, coronary care or similar special care units; and outpatient or inpatient hospital miscellaneous services and supplies when necessary to treat a condition of illness or injury. Inpatient pre-admission and length of stay certification are required from the claim administrator. Hospital emergency room related charges are paid at 80% after a $500 co-payment instead of the deductible at In-Network or Out-of-Network providers.
2. Physician profession fees. Physician office visits including mental health therapy and chiropractic therapy (but not x-ray, lab or other services) are covered in full, after at $40 co-pay, at the lower of HealthLink approved pricing or reasonable and customary. **Emergency physician telemedicine including authorization of prescriptions are covered in full after a $15 co-pay by calling 1-855-717-6800. You pay the $15 by debit or credit card.** Chiropractic visits are limited to 12 visits per calendar year. Steroid epidural injections for back/neck pain are covered subject to deductible and coinsurance and Exclusion #5 on page 5.
3. Lab work, x-ray and imaging to treat or monitor an existing illness are subject to the deductible and coinsurance except that lab charges are paid in full without a deductible or copayment.
4. Services of a registered physical therapist or occupational therapist. Services of a speech therapist to restore speech loss due to an injury, stroke or surgery. Therapies limited to 24 visits per calendar year.
5. Initial purchase of leg, arm, neck and back braces, artificial limbs and other prosthetic devices. Oxygen, blood and related administration charges. Durable medical equipment rental or purchase, at the claim administrator's option, when prescribed by a physician and where such rental type equipment is not customarily used except for medical purposes.
6. PPO and Non-PPO professional ground service is paid at 80% after the deductible, when medically necessary to transport a patient to the nearest hospital where required treatment can be provided. Air ambulance is not covered. An annual subscription for prepaid air transport will be reimbursed to you 100% up to $100 per year when you file an itemized receipt for your payment to Mutual Medical at 416 Main St., Peoria, IL 61602.
7. Hospice or home health care services when the service provider is not a relative and does not normally reside in the same home as the patient, but only if prescribed by a physician and approved by the Claim Administrator.
8. Oxygen, blood and administration charges. TPN and FDA approved injectable medications that are not excluded by the Plan, when medically necessary and obtained from a vendor designated by the Plan.
9. Preventative care as required by the ACA including office visits, exams, tests and immunizations are covered in full without a deductible or co-pay at PPO providers, and paid at 50% of maximum allowable charges after the deductible at non-PPO providers. If a claim, or portion thereof, is billed with a diagnosis other than preventative screening, the claim or that portion will be paid under the deductible and co-insurance rather than preventative benefits.
10. PKU formula and low protein modified food products from birth to age six, newborn hearing screening, necessary rescreening, audiological assessment and follow-up and initial amplification, treatment for autism spectrum disorders, lead testing.

HSA 4,000

This plan covers the same scope of benefits as the Major Medical 2,700 except that the deductible is $4,000 per person ($8,000 family) for expenses incurred in a calendar year. After the deductible, you pay 20% up to the out of pocket limit of $5,500 per person ($11,000 family) for expenses incurred in a calendar year. The only benefits not subject to the deductible are ACA required preventive services and these are payable at 100% of PPO allowances and 50% of non-PPO reasonable and customary charges. HSA members are not included in the Prescription Drug Plan, but may use Good Rx or the discount program of your choice and file itemized pharmacy receipts (showing the amount you paid, the Rx, patient name and date dispensed) to Mutual Medical at P.O. Box 689, Peoria, IL 61652 if you need this expense applied to your deductible. The same exclusions of the Prescription Drug Plan on the next page herein apply.

MAXI PLAN and MAXI PLAN II

If you have other coverage that is secondary to this Plan you may elect the Maxi Plan. The Maxi Plan covers the same scope of eligible expenses as Major Medical Benefits without a deductible or co-insurance. All covered services are payable at 100% except that inpatient hospital billed charges are paid up to a maximum of $1,500 per admission. The Maxi Plan also pays in full for routine medical exams and the co-pays under any drug plan. A person may change from the Major Medical Plan to the Maxi Plan, or vice-versa, at any time. Except for inpatient hospital billed charges, the same PPO provisions apply that are in the Major Medical Benefits. The Maxi II is the same as the Maxi Plan except that Maxi II does not cover hospital charges, prescription drugs or oncology expenses.

MEDICAL REIMBURSEMENT PLAN (MRP)

Employees with other employer sponsored group medical coverage, including Tri-Care, may elect only this plan unless an exception is made by the Plan Sponsor. Active employees or their spouses who have Medicare are also eligible but not required to take this Plan. However, the MRP has tremendous advantages if you have Medicare Part B. First, the MRP does not have the $25,000 exclusion on many services shown in the Limitations and Exclusions. Medicare is accepted by virtually all hospitals in the United States and by far more doctors than your regular health plan PPOs. Moreover, Medicare Part B puts a coast to coast cap on all participating provider charges so you do not have to worry about reasonable and customary and maximum allow charges as with major medical plans. For example, this can save you $50,000 or so on an air transport case, or hundreds of thousands of dollars on a kidney dialysis case in return for a small monthly investment in Medicare Part B premiums. And the MRP reimburses all of your Medicare A and B deductibles and co-insurance.

Employees other than those above may elect this option only with approval of the Plan Sponsor. This plan can significantly increase your overall benefits. Deductibles, co-pays, and co-insurance (but not co-insurance on your other plan's non-PPO hospitals unless authorized by this Plan) on your other medical and prescription plan are covered in full with no annual or lifetime dollar limit. Clinical trials except the drug, ER and preventative are covered in full as secondary to your other plan. Benefits are paid directly to you when you send a copy of your other plan's explanation of benefits, or a copy of your prescription receipts showing your co-pays, to Mutual Medical at 416 Main Street, Peoria, IL 61602. FAX 309-674-5420. Write the health care provider's name and phone number on the explanation of benefits.

THE AFFORDABLE CARE PLAN (ACP)

*** No employee premium contribution * No deductible, no co-pays, no co-insurance**
*** No overall annual or lifetime dollar limits * No pre-existing condition limits**

The ACP is designed for individuals whose benefits are expected by the Claim Administrator to exceed $35,000 or more in a year and/or any knee or hip replacements, neck, back and shoulder surgery. Each year qualifying individuals may remain in the ACP, or elect to come back to one of the major medical plans at any time. Under the ACP you may select the carrier of your choice from the market without having to answer health questions or being subject to pre-existing condition limits. The ACP will pay all of your premiums and will also reimburse you for all deductibles, co-pays and co-insurance for both medical and prescription drugs under your chosen fully insured health care plan. Clinical trial expenses except for the drug, and preventative and emergency room services are covered. Arrangements can be made to qualify the first of any month with a one week notice. While not everyone can qualify, everyone in the group benefits because of reduced claims that affect employee contributions. To determine if you qualify, contact Mutual Medical at 1-800-448-4689, or consult with the individual in your HR department that handles health insurance. If you do not qualify for all of the features of the Affordable Care Plan, you may qualify for a modified version of the plan as determined by you and the Plan Sponsor.

PRESCRIPTION DRUG PLAN

(Only available with Major Medical and Maxi Plan unless exception made by Plan Sponsor)

Insulin, insulin syringes, diabetic supplies, and most FDA approved drugs that can only be purchased with a prescription may be obtained from a retail pharmacy for the copayments listed below for up to a 30-day supply. Up to a 90-day supply is available through Script Care mail order service for double the retail copayments. Formulary drug lists are available at www.scriptcare.com or call Script Care member services at 800.880.9988.

Generic $15, Formulary Brand $70, Non-Formulary Brand $110, Specialty 20% maximum of $200.

The out of pocket expense limit for covered prescription drugs is $2,500 per Individual and $5,000 per Family per calendar year. If you purchase a brand name drug when the generic is available you pay the brand copay plus the difference in ingredient cost. Certain non-formulary brand name drugs are only covered if the formulary brand name drug has been used unsuccessfully as determined by Script Care and your physician. For certain maintenance drugs only the first 3 refills at retail pharmacies are covered by this Plan. If you require more than 3 refills you should use the mail order program by having your prescribing physician call the Script Care mail order physician's line at 800.880.9988. Specialty drugs or injectable drugs, other than insulin, not receiving special authorization from the Claim Administrator will not be covered providing that any drug that cost over $15,000 per year will not be covered or authorized, but you may call Mutual Medical if you need assistance with a manufacturer's subsidy or for possible ACP enrollment. Drugs excluded include: those not approved by the FDA for the purpose prescribed; sexual enhancement drugs; infertility; hair growth; or cosmetic purposes.

VISION BENEFIT

Routine vision exams are covered in full after a $20 co-pay up to a maximum of $45 per person for expenses incurred in a calendar year.

LIMITATIONS AND EXCLUSIONS

The Plan will not pay for:

1. Hospital or related physician charges during inpatient admissions primarily for care which can be provided safely on an outpatient basis as determined by the claim administrator. Charges exceeding reasonable and customary or the maximum allowable charge as determined by the claim administrator. Hospital admissions commencing on or other services or appliances received before an individual's effective date of coverage or after termination of coverage. Custodial care primarily for assistance with activities of daily living. Care that is provided or can be provided at home, by a nursing home, skilled nursing facility, step-down unit, or long-term care facility. Education or training not specifically mentioned as a benefit of the Plan. Expenses related to non-covered services or procedures including complications. Services or supplies not specifically listed as a benefit of the Plan. Expenses not related to the diagnosis or treatment of an illness or injury unless specifically included as a benefit.
2. Job related injuries or illnesses covered by or pending under Worker's Compensation or similar legislation, or for which a final decision has not been made by the Industrial Commission on a claim filed under Worker's Compensation. Expenses payable by Medicare, or which would have been payable if the person had properly enrolled in Medicare, except where contrary to law. Expenses for which you, the employee, are not liable for payment including expenses on adult dependents where you have not assumed legal liability for medical bills. Expenses covered by or pending under auto, property and casualty, or liability insurance or for which another party is liable. Self-inflicted injury or illness. Injuries sustained by a person while committing a felony, participating in a riot, or while under the influence of illegal drugs. Injury or illness due to war or act of war or while serving on active military duty.
3. Routine foot care such as trimming nails or callouses. Orthopedic shoes or orthotics. IQ testing. Personal comfort or convenience items such as television rental, barber services, special or guest meals, telephone calls, travel expenses, stair lifts, van lifts Hearing aids or eyeglasses and tests for the fitting thereof. Wigs and hair transplants. Expenses denied by an HMO or other health care plan for (a) lack of pre-treatment approval,(b) use of non-network providers, or (c) failure to follow claim procedures.
4. Cosmetic surgery unless necessary to correct congenital deformity of a dependent child or repair traumatic injuries incurred while covered under the Plan. Rhinoplasty or any nose surgery except for tumors or cysts or to repair nasal injury incurred while covered under the Plan. Otoplasty. Blepharoplasty unless medically necessary and approved by the Plan. Radial keratotomy or a similar procedure, weight reduction, bariatric surgery, exercise or fitness programs except for phase 1 or 2 cardiac rehabilitation following cardiac surgery or a heart attack.
5. Expenses related to sex changes, penile implants, reverse sterilization, infertility, sexual dysfunction, dependent daughter pregnancy, abortions except for therapeutic abortions, marriage counseling or sexual therapy. Hospital charges for a vasectomy or other surgery that can be performed in a physician's office. Home uterine monitoring devices. Mastectomy in the absence of a malignancy. Breast reduction or enlargement except for post mastectomy reconstruction of a covered mastectomy. Growth hormones. Epidurals for back/neck pain beyond 3 injections in a consecutive 12-month period. Non-surgical inpatient admissions for back pain.
6. Services of a dentist except unless related to the removal of impacted teeth, tumors or cysts. Treatment for TMJ or to alter vertical dimension. Expenses related to jaw surgery except for fracture repair. Eyeglasses, contact lenses, and routine vision care. Hearing aids or tests for the fitting thereof.
7. Services not authorized by a physician as necessary treatment, or services (including organ transplants) which are considered experimental, investigational or not medically necessary by Medicare criteria. Services or supplies received when a person travels to another country primarily for the purpose of obtaining such services or supplies. Expenses related to kidney dialysis beyond 150% of the Medicare National Fee of the Physician's Fee Reference.
8. Expenses related to a hospital admission or course of treatment beyond $25,000, provided that the Plan may elect to ignore this limit if necessary to protect the employee financially when there are no better financial options available for the employee. Benefits beyond $25,000 for non-emergency knee or hip replacements, neck, back or shoulder surgery. These limits do not apply to the MRP or ACP. Air ambulance or air transport.

CLAIM PROCEDURES

ALWAYS PRESENT YOUR HEALTH PLAN ID CARD WHEN RECEIVING COVERED MEDICAL SERVICES because the card contains billing instructions for your hospital and doctor. Benefits may be paid directly to the provider of service, the Plan reserves the right and option of paying benefits directly to you, or in the event of your death to a relative determined by the claim administrator (does not apply to care received in Missouri). Claims must be filed within 180 days after the end of the calendar year in which the expense is incurred.

You may contact the Claim Administrator for additional clarification on how a claim was paid or denied. If you do not agree with the Claim Administrator's reason for denying a claim or issuing a rescission of coverage, you may file a written appeal to the Plan Administrator within 180 days after the claim is denied or rescission issued. The appeal should indicate: Employee Name and Social Security Number, Patient Name, name of Plan Sponsor, Claim Number of Denied Claim, Date(s) of Service, Provider(s) of Service, Specific reason(s) you feel the claim should be paid including reference to Plan provisions, Relevant documents or other information. When reviewing your appeal, the Plan Administrator will take into account all information you submit without regard to whether the information was considered when the claim was denied. If the denial was due to medical judgment, the Plan Administrator will consult with an appropriate medical professional who was not, directly or indirectly, involved with the claim denial. You may obtain information relevant to a denied claim, including the name of any medical expert who gave advice relative to the denial, free of charge. The Plan will provide you, free of charge, with any new or additional evidence considered or generated in connection with the claim or new or additional rationale, for the Plan's decision as soon as possible in advance of the appeal decision date for your response, prior to that date. A written response to the appeal will be made within 60 days after the Plan Administrator receives the above necessary information. The response will be sent to the employee's address currently on file, or to a different address at your request. Any claim denial or appeal denial will sufficiently identify the claim involved, the diagnosis code, the treatment code, the denial code, and their corresponding meanings; the Plan's applicable standards; and, if an appeal, a discussion of the Plan's decision.

If the appeal is denied, you may file a request for an external appeal of the decision within 123 days of receipt of notice of the decision (or the first business day following that date if a weekend or legal holiday). Within 5 days of the receipt of this request the Plan will determine if you (1) were covered under the Plan at the relevant time, (2) met the requirements for eligibility under the Plan, (3) exhausted the Plan's internal appeal procedures, and (4) have provided the Plan all information and forms to process the external review. Within 1 day of determining the above, the Plan will notify you whether you are eligible for external review or the information needed to be eligible for external review and the reasons for the plan determination. If eligible, the Plan will randomly assign your appeal to an independent review organization (IRO) in accordance with the requirements of, and in compliance with, DOL Technical Release 2010-01. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. The IRO will timely notify you in writing of your eligibility and acceptance for external review. You may submit additional information to the IRO as allowed by the IRO in the notice. The Plan will provide the IRO all related documents within 5 days of assignment of the IRO. If the Plan fails to do so the IRO may terminate the external review and reverse the claim denial and notify you within one business day after making that decision. The IRO must provide the Plan with any information you submit within one business day. The external review may be terminated if the Plan reverses its denial based on this information. The Plan will notify you within one business day after reversing the denial upon reconsideration. The IRO will decide the external appeal after reviewing all information and will review the claim de novo and not bound by any decisions or conclusions reached during the Plan's internal claims and appeal processes. In addition, the IRO will consider, as appropriate:

(1) your medical records, (2) the attending provider's recommendation, (3) reports by health care professionals and other documents submitted by you, the Plan, or your provider, (4) the terms of the Plan, (5) appropriate practice guidelines, (6) any applicable clinical review criteria developed and used by the Plan, and (7) the opinion of the IRO clinical reviewers, all in accordance with the requirements of DOL Technical Release 2010-01. The IRO will provide written notice of its decision within 45 days of its receipt of your appeal. The IRO's notice of decision will comply with the requirements of DOL Technical Release 2010-01 and will contain: (1) a general description of the reason for the request for external review, including information sufficient to identify the claim; (2) the date the IRO received the assignment to conduct the external review and the date of the IRO decision; (3) references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; (4) a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; (5) a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you; (6) a statement that judicial review may be available to you; and (7) current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by you, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws. Upon receipt of a notice of a final external review decision reversing the denial, the Plan immediately must provide coverage or payment for the claim. If your external appeal is denied, you have a right to file a civil action under Section 502 of ERISA provided you file it within 90 days after the appeal is denied.

PRIVACY INFORMATION

The Claims Administrator may release to, or obtain from any party, without consent of or notice to any person, any information the Plan Administrator or Claims Administrator deems necessary to carry out the provisions of the Plan. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Claims Administrator may only use or disclose such information when related to treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Claims Administrator such information as may be necessary to carry out this provision.

Only individuals, and their clerical support staff, who are involved with Plan administration, supervision or management, shall be given protected health information, and only to the extent necessary to perform duties assigned by the Plan Administrator. In addition, the Plan Sponsor hereby certifies and agrees that it will: (a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law; (b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan; (c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information; (d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor; (e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware; (f) Make available protected health information in accordance with 45 C.F.R. 164.524; (g) Make available health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526; (h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528; (i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.; (j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and (k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

STATEMENT OF RIGHTS UNDER THE NEWBORN'S AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital lengths of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your plan administrator.

LEGISLATION AND OTHER PROVISIONS

If provisions of the Plan conflict with applicable State or Federal laws, present or future, such legislation shall prevail. You should rely upon this document to estimate or determine benefits available. Information you receive from any source will not be valid if it conflicts with the language of this Plan. If the Plan determines that provisions herein are incompatible with another health care plan, the Plan may take any action it deems appropriate to best serve the interest of the Plan and the individual Plan member. Any retroactive termination of coverage must be approved by the Plan. If claims on an individual are expected by the Plan to exceed $50,000 in a consecutive 12 month period, the Plan reserves the right to determine the health care provider. If a provider is not approved, benefits will be paid at zero. If necessary to avoid financial hardship to the employee, the Claim Administrator may elect to negotiate additional payments for kidney dialysis related expenses or a kidney transplant. Where it is to the financial benefit of the Plan and an individual, the Plan may assist an individual financially in retaining or obtaining alternate health plan coverage.

NOTIFICATION OF COBRA RIGHTS AND REQUIREMENTS

Coverage may continue in certain instances where coverage under the Plan would normally end. The information below advises you of your rights and obligations under this continuation coverage, made possible under federal legislation commonly referred to as COBRA. A person who is eligible for continuation is called a "qualified beneficiary." Each qualified beneficiary, or the parent or legal guardian of a minor qualified beneficiary, has a right to make a separate election for a qualified beneficiary or for such minor. The events making a person eligible are called "qualifying events." Questions may be directed to the plan administrator. This notice describes your rights under this continuation coverage under the Plan and you may contact the Plan Administrator with questions or for more information.

Eligibility for Continuation The following qualifying events make a Plan participant eligible as a qualified beneficiary. If an employee's medical coverage terminates because of termination of employment (other than for gross misconduct) or reduction of hours, the employee is a qualified beneficiary and may elect to continue the medical coverage. If you are a spouse/dependent of an employee, and were covered under the Plan at the time of the qualifying event, or born of the employee or adopted by the employee during the period of COBRA continuation and qualify as a "dependent" under the Plan, you have the right to continuation coverage if medical coverage terminated for any of the following events: (1) Death of an employee (2) Termination of the employee's employment (other than for gross misconduct) or reduction in hours worked (3) Divorce or legal separation (4) Employee becomes covered under Medicare (5) Dependent child no longer meets the definition of an eligible dependent under the Plan (6) Substantial reduction in retiree coverage due to employer bankruptcy reorganization.

Notice of Qualifying Event/Election Period The Plan Sponsor will provide notice of the availability of continuation coverage when the following qualifying events occur: (1) Employee's death (2) Loss of coverage due to employee's termination of employment (other than for gross misconduct) or reduction of work hours (3) Loss of coverage due to Medicare entitlement (4) Substantial reduction in retiree coverage due to employer bankruptcy reorganization. Plan participants must notify the Plan Sponsor in writing within 60 days of a divorce, separation, child losing dependent status in order to arrange for continuation coverage. The Plan Administrator will then provide the plan participants an election notice. An election for continuation coverage must be made within the 60-day election period beginning on the later of the date the coverage would end because of one of the qualifying events described above or the date the participant(s) is sent COBRA notice. In order for the Plan Administrator to notify you of your COBRA rights, it is important for you to keep the Plan Administrator advised of your current address.

Period of Continuation will terminate on the earliest of the following dates: (1) The end of: (a) 18 months, in the case where the coverage ended because of termination of employment (other than for gross misconduct) or reduction of hours (b) 36 months total, for dependents of the plan participant who have other including second qualifying events (c) 29 months, for employees and dependents if either the employee or a qualified dependent beneficiary is classified as disabled under the terms Title II or XVI of the Social Security Act within 60 days of the time of termination of employment or reduction of hours provided you notify the Plan Sponsor in writing within 60 days after you receive notice of disability from the Social Security Administration, and providing that you provide such notice to the Plan Sponsor before the end of the initial 18 months of COBRA continuation (2) The date after the COBRA election on which the person first becomes: (a) covered under any other group health plan, as an employee or otherwise (NOTE: Qualified beneficiaries, i.e., employee, spouse and/or dependents, who become covered by another group insurance program, are allowed to continue COBRA coverage only if the other group insurance plan has a pre-existing condition limitation or exclusion clause that applies to that individual's coverage. COBRA coverage will continue only to the time period specified above, or if earlier, when the pre-existing conditions restriction no longer applies) (b) entitled to benefits under Medicare (3) The date the premium is not paid (4) The date the Plan Sponsor no longer provides group health coverage to any of its employees (5) In the case where continuation of coverage is extended to 29 months, this extended coverage will be terminated the first day of the month following 30 days after the final determination that the individual is no longer disabled. You are required to notify the Plan Sponsor within 30 days of any event described above which would cause COBRA coverage to end.

Election and Premium Payment If continuation coverage is chosen, this coverage will be identical to the coverage provided under the Plan prior to the qualifying event. Qualified beneficiaries choosing to continue coverage under COBRA must pay the entire premium amount (plus a 2% administration charge, or plus 50% during an 11 month disability extension) to the Plan Sponsor on a monthly basis. (Monthly premium rates are subject to change annually.) Payroll deduction is not available to COBRA participants. Checks should be made payable to the Plan Sponsor. The qualified beneficiary's first payment deadline is 45 days after the date of their continuation election. The subsequent payment due date is the first day of the month for which coverage is purchased with a deadline of 30 days after the due date. Failure to pay premiums by these deadlines will result in termination of coverage. Information on current premiums is available by contacting the Plan Sponsor. Failure to elect COBRA coverage may cause you to avoid having pre-existing conditions apply to you in other group plans if you have more than a 63-day gap in health coverage, and will cause you to lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition if you do not exhaust COBRA coverage. You have a right to request special enrollment under certain plans that you are eligible for if you (a) apply within 30 days of coverage termination related to the initial qualifying event or (b) apply within 30 days of exhaustion of COBRA continuation coverage, If you reject COBRA coverage before the deadline for election, you may still elect COBRA before the election deadline by completing a new election form and your coverage will be effective on the date the form is received by the Plan Administrator or its designee.