PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

BULLOCH COUNTY BOARD OF COMMISSIONERS EMPLOYEE HEALTH CARE PLAN

Effective April 1, 2021

Benefit Year – January 1 to December 31

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INTRODUCTION

This document is a description of Bulloch County Board of Commissioners Employee Health Care Plan (the Plan), which replaces and supersedes all previous Plan Documents. No oral interpretations can change this Plan.

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 912-764-6245. Covered Persons may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Coverage under the Plan will take effect for an eligible person when the eligible persons satisfy the Waiting Period and all the eligibility and enrollment requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility, and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization management or other Utilization Management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

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

The Plan is a cost sharing mechanism for certain health care services and supplies used by a Covered Person. The Plan is not responsible for the efficiency and integrity of the health care providers delivering such health care services and supplies. The Plan is not liable in any way for the effect of delivery of such health care services and supplies or the results of action taken as a result of a health care service or supply being limited or not covered by the Plan.

In accordance with 85 FR 26351, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," as updated by EBSA Disaster Relief Notice 2021-01, notwithstanding any existing Plan language to the contrary, the Plan will disregard the period from March 1, 2020 until the earlier of (1) sixty (60) days after the end of the public health emergency relating to COVID-19 and declared pursuant to 42 U.S.C. § 247d or (2) one year from the date the individual was first eligible for relief, for

purposes of determining the following periods and dates:

1) The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA section 701(f) and Internal Revenue Code section 9801(f);
2) The 60-day election period for COBRA continuation coverage under ERISA section 605 and Internal Revenue Code section 4980B(f)(5);
3) The date for making COBRA premium payments pursuant to ERISA section 602(2)(C) and (3) and Internal Revenue Code section 4980B(f)(2)(B)(iii) and (C);
4) The date for individuals to notify the Plan of a qualifying event or determination of disability under ERISA section 606(a)(3) and Internal Revenue Code section 4980B(f)(6)(C);
5) The date within which individuals may file a benefit claim under the Plan's claims procedure pursuant to 29 CFR 2560.503-1;
6) The date within which Claimants may file an appeal of an Adverse Benefit Determination under the Plan's claims procedure pursuant to 29 CFR 2560.503-1(h);
7) The date within which Claimants may file a request for an external review after receipt of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination pursuant to 29 CFR 2590.715-2719(d)(2)(i) and 26 CFR 54.9815-2719(d)(2)(i); and
8) The date within which a Claimant may file information to perfect a request for external review upon a finding that the request was not complete pursuant to 29 CFR 2590.715-2719(d)(2)(ii) and 26 CFR 54.9815-2719(d)(2)(ii).

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

This document summarizes the Plan rights and benefits for Covered Persons and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning. If a word or phrase has a specific meaning, it starts with a capital letter and is either defined in the Defined Terms section or in the text of this document where it occurs.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains the continuation options that are available when a person's coverage under the Plan ceases.

SCHEDULE OF BENEFITS

Only a general description of health benefits covered by this Plan is included in this document. A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

Verification of Eligibility 800-680-8728

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

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Allowable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The following services must be precertified or reimbursement from the Plan may be reduced. If the Covered Person does not receive authorization as explained in the Utilization Management Services section, the benefit payment will be reduced by 50% up to a maximum of $500. The penalty for failure to pre-certify inpatient admissions will apply only to the facility charge for the inpatient stay.

Until the end of the public health emergency related to COVID-19, the Plan does not impose prior authorization or other medical management requirements for in vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are (a) approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, (b) for which the developer has requested or intends to request emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act unless and until such request is denied or is not submitted within a reasonable timeframe, (c) that are developed in and authorized by a State that notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19, (d) that the Secretary of Health and Human Services determines appropriate in guidance.

Hospital Admissions
Skilled Nursing Facility Admissions
Outpatient Surgery

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be pre-certified as set forth in this document.

NOTE: When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.

Please see the Cost Management section in this booklet for details.

PREFERRED PROVIDER NETWORK PROVISIONS

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment percentage will be applied to the cost of certain non-Network services. The Covered Person will be responsible for charges in excess of the Allowable Charge. For Emergency services from Non-Network providers, the amount payable by the Plan will be determined based on the non-network provider's billed charges.

- If covered services are not available in the Network (e.g., ambulance)
- If a Covered Person has no choice of Network Providers in the specialty or for the procedure or treatment that the Covered Person is seeking.
- If a Covered Person has a Medical Emergency requiring immediate care.
- If a Covered Person receives ancillary Physician (Assistant Surgeon, Pathologist, Radiologist, ER Physician) or anesthesia services by a non-Network Provider (who was not specifically selected by the Covered Person) at a Network facility or when a Network Provider sends laboratory samples, x-rays, or other diagnostic test results to a non-Network Provider for review (this applies only if there is an office charge from the Network Provider).
- If a non-Network Provider covers for a Network Provider (due to vacations, etc).
- If a Dependent Child is attending school in a geographical area where a Network Provider is not available.
- If a Covered Person is directed to a Non-Network Provider by the Plan's Medical Management Administrator.

If the Medical Management Administrator approves a treatment plan in which the Covered Person is referred to a Non-Network Provider, this care may be covered as if that Provider was a Network Provider. The Plan Administrator reserves the right to negotiate discounts with providers of service, and those discounts will be used to reduce the amount of otherwise covered expenses considered for payment by the Plan.

Additional information, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

SUMMARY OF BENEFITS
PPO PLUS PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM PLAN YEAR BENEFIT AMOUNT	None (unlimited)	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR	Amounts applied to the Deductible for charges from Network Providers will NOT be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.	
Per Covered Person	$400	$800
Per Family Unit	$1,200	$2,400
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers will NOT be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa.	
Per Covered Person	$1,500	Unlimited
Per Family Unit	$4,500	Unlimited
The Plan will pay the designated percentage of Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.		
Cost containment penalties		
Copayments		
Non-Covered Expenses		
Amounts that exceed the Allowable Charge or benefit maximums		

COVERED SERVICES

Percentages listed indicate the portion of the Allowable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Copayments and deductibles are the Covered Person's responsibility to pay.

PREVENTIVE CARE		
Routine Well Care	100%, deductible waived	Not Covered *Note: Benefits for Qualifying Coronavirus Preventive Services are 100%, deductible waived*

Includes: office visits, routine physical examination, x-rays, laboratory blood tests, immunizations/flu shots, gynecological exam and Pap testing (limited to an annual screening), Prostate Specific Antigen (PSA) testing.

Effective on the Specified Date (as defined below), the Plan will cover Qualifying Coronavirus Preventive Services (as defined below) with no cost sharing.

Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is (a) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or (b) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Specified Date means the date that is 15 business days after the date on which a recommendation is made relating to the Qualifying Coronavirus Preventive Service.

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE CARE		
Mammogram Limited to one per Calendar Year	100%, deductible waived	50% after deductible
Endoscopies (e.g., colonoscopy or sigmoidoscopy) Colonoscopies limited to persons over age 50 and/or in accordance with AMA guidelines.	100%, deductible waived	Not Covered
Bone Density	100%, deductible waived	Not Covered
Vision Exam (solely to determine vision correction)	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Hearing Exam	Not Covered	Not Covered

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
SUPPLEMENTAL ACCIDENT		
Eligible charges Claims must be incurred within 90 days of accident	100%, deductible waived up to $300, then 80% after deductible	100%, deductible waived up to $300, then 50% after deductible

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board *Benefits payable at the facility's semi-private room rate unless only a private room is available or is medically necessary*	80% after deductible	50% after deductible
Intensive Care Unit *Benefits payable at facility's ICU rate.*	80% after deductible	50% after deductible
Emergency Room for Medical Emergency only *(see defined terms section of this document)* Non-Emergency Use of the Emergency Room	80% after deductible 50% after deductible	50% after deductible 50% after deductible
Routine Well Newborn Care (Inpatient Care)	80% after deductible	50% after deductible
Inpatient Private Duty Nursing	Not Covered	Not Covered
Inpatient Prescription Drugs	80% after deductible	50% after deductible
Pre-admission Testing	80%; deductible waived	50%; deductible waived
Outpatient Hospital Services	80% after deductible	50% after deductible

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PHYSICIAN SERVICES		
Inpatient visits *(includes inpatient well newborn care)*	80% after deductible	50% after deductible

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PHYSICIAN SERVICES		
Emergency Room services for Medical Emergency only *(see defined terms section of this document)*	80% after deductible	50% after deductible
Non-Emergency Use of the Emergency Room	50% after deductible	50% after deductible
Office visit only - Primary Care Provider (PCP)	100% after $25 copayment, deductible waived	50% after deductible
Office visit only – Specialist	80% after deductible	50% after deductible
Telemedicine visit	Same as Office Visit benefit	
Office visit services *These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.*	80% after deductible	50% after deductible
Office services (not associated with office visit) – no office visit charge *These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.*	**PCP**: 80% after deductible **Specialist**: 80% after deductible	50% after deductible
Allergy testing	**PCP**: 80% after deductible **Specialist**: 80% after deductible	50% after deductible
Injections (by Physician) *Includes allergy injections and serum*	**PCP**: 80% after deductible **Specialist**: 80% after deductible	50% after deductible
Inpatient Surgery	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Office Surgery	80% after deductible	50% after deductible
Oral Surgery	80% after deductible	50% after deductible
Extraction of Impacted Wisdom Teeth	80% after deductible	50% after deductible
Second Surgical Opinion	80%; deductible waived	50%; deductible waived
Endoscopies (non-routine)	80% after deductible	50% after deductible
Contraceptive Management		
Office Visit	80% after deductible	50% after deductible
Injections	80% after deductible	50% after deductible
Implants	80% after deductible	50% after deductible
Intrauterine Device	80% after deductible	50% after deductible
Diaphragm	80% after deductible	50% after deductible
Female condom	80% after deductible	50% after deductible
Over the Counter Contraceptives	Not Covered	Not Covered

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Testing for the 2019 Novel Coronavirus (COVID-19) *See limits in Medical Benefits section*	100%, deductible waived	100%, deductible waived
Ambulance Service	80% after deductible	80% after deductible

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Skilled Nursing Facility *Benefits payable at the facility's semiprivate room rate.* *Calendar Year Maximum: 60 days*	80% after deductible	50% after deductible
Urgent Care Center	80% after deductible	50% after deductible
Independent X-ray Services (i.e., not in Physician office or Hospital and non-routine) *Does not include MRI, MRA, CT Scans, PET Scans or DEXA scans*	80% after deductible	50% after deductible
Independent Laboratory Services (i.e., not in Physician office or Hospital and non-routine) *Does not include MRI, MRA, CT Scans, PET Scans or DEXA scans*	80% after deductible	50% after deductible
Labcorp	100%, deductible waived	Not applicable
MRI/MRA, CT/CTA Scan, PET Scan performed in free-standing diagnostic center	80% after deductible	50% after deductible
MRI/MRA, CT/CTA Scan, PET Scan performed in outpatient Hospital	80% after deductible	50% after deductible
Genetic Testing *Note: Genetic Tests are covered* ***only*** *if (1) they are Medically Necessary and meet the conditions listed in the Medical Benefits section of the Plan.*	80% after deductible	50% after deductible
Organ Transplants	80% after deductible	50% after deductible
Pregnancy *Pregnancies of Dependent children are not covered.*	100% after $250 copayment for inpatient hospital services, deductible waived 100% after $250 copayment for inpatient physician services, deductible waived All other charges associated with pregnancy are subject to deductible and co-insurance.	50% after deductible
Sterilization	Not Covered	Not Covered
Impotence Diagnosis **Impotence Testing and Treatment**	80% after deductible Not Covered	50% after deductible Not Covered
Infertility Diagnosis **Infertility Testing and Treatment**	80% after deductible Not Covered	50% after deductible Not Covered
Outpatient Private Duty Nursing *Limited to 120 visits per Calendar Year*	80% after deductible	50% after deductible
Home Health Care *Calendar Year maximum: 120 visits*	80% after deductible	50% after deductible
Hospice Care *Calendar Year maximums:* *30 inpatient days and 15 outpatient visits*	80% after deductible	50% after deductible
Occupational Therapy *Calendar Year maximum: 60 visits*	80% after deductible	50% after deductible
Speech Therapy	80% after deductible	50% after deductible
Physical Therapy *Calendar Year maximum: 60 visits*	80% after deductible	50% after deductible
Cardiac rehabilitation therapy	80% after deductible	50% after deductible
Chemotherapy	80% after deductible	50% after deductible
Radiation Therapy	80% after deductible	50% after deductible

PPO PLUS PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Infusion Therapy	80% after deductible	50% after deductible
Jaw Joint/TMJ *Calendar Year Maximum: $1,000*	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Injectables administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting	80% after deductible	50% after deductible
Diabetic Supplies	80% after deductible	50% after deductible
Diabetic Education	80% after deductible	50% after deductible
Autism	80% after deductible	50% after deductible
Wig After Chemotherapy *Lifetime maximum: 1 wig*	80% after deductible	50% after deductible
Prosthetics	80% after deductible	50% after deductible
Orthotics – foot	80% after deductible	50% after deductible
Orthotics – other	80% after deductible	50% after deductible
Hearing Aid	Not Covered	Not Covered
Pain Management	80% after deductible	50% after deductible
Spinal Manipulation Chiropractic *Calendar Year maximum: $500*	80% after deductible	50% after deductible
Attention Deficit Hyperactivity Disorder Treatment	80% after deductible	50% after deductible
Mental Disorders/Substance Abuse (combined)		
Inpatient *Benefits payable at the facility's semi-private room rate or ICU rate, as applicable*	80% after deductible	50% after deductible
Partial Hospitalization	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Office Visit	100% after $25 copayment, deductible waived	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE
PPO PLUS PLAN

Refer to the Prescription Drug section for details on the Prescription Drug benefit.

PRESCRIPTION DRUG BENEFIT	
Prescription Drug Deductible Amount	Not Applicable
Pharmacy Option (30 Day Supply)	
Generic Drugs	$15 Copayment*
Brand Name Drugs (Generic not available)	$35 Copayment*
Brand Name Drugs (Generic available)	25% Coinsurance
Mail Order Option (90 Day Supply)	
Generic Drugs	$30 Copayment*
Brand Name Drugs (Generic not available)	$65 Copayment*
Brand Name Drugs (Generic available)	25% Coinsurance

*If the actual cost of a drug is less than the co-payment amount, the Covered Person will be charged only the cost of the drug.

Generic Drug Incentive

When a doctor indicates that a brand name drug must be filled when a generic drug is available, documentation of Medical Necessity must be submitted for review. If a determination is made that the brand name drug prescription is Medically Necessary, the brand name drug co-payment will apply.

SUMMARY OF BENEFITS
PPO BASIC PLAN

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM PLAN YEAR BENEFIT AMOUNT	None (unlimited)	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
DEDUCTIBLE, PER CALENDAR YEAR	Amounts applied to the Deductible for charges from Network Providers will NOT be used to satisfy the Deductible for charges from Non-Network Providers and vice versa.	
Per Covered Person	$400	$800
Per Family Unit	$1,200	$2,400
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Network Providers will NOT be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Network Providers and vice versa.	
Per Covered Person	$2,500	Unlimited
Per Family Unit	$7,500	Unlimited
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%.		
Cost containment penalties		
Copayments		
Non-Covered Expenses		
Amounts that exceed the Allowable Charge or benefit maximums		

COVERED SERVICES

Percentages listed indicate the portion of the Allowable Charge that the Plan will pay in benefits subject to all exclusions and limitations described in this document. Copayments and deductibles are the Covered Person's responsibility to pay.

PREVENTIVE CARE		
Routine Well Care	100%, deductible waived	Not Covered *Note: Benefits for Qualifying Coronavirus Preventive Services are 100%, deductible waived*

Includes: office visits, routine physical examination, x-rays, laboratory blood tests, immunizations/flu shots, gynecological exam and Pap testing (limited to an annual screening), Prostate Specific Antigen (PSA) testing

Effective on the Specified Date (as defined below), the Plan will cover Qualifying Coronavirus Preventive Services (as defined below) with no cost sharing.

Qualifying Coronavirus Preventive Service means an item, service, or immunization that is intended to prevent or mitigate coronavirus disease 2019 and that is (a) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or (b) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

Specified Date means the date that is 15 business days after the date on which a recommendation is made relating to the Qualifying Coronavirus Preventive Service.

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE CARE		
Mammogram *Limited to one per Calendar Year*	100%, deductible waived	50% after deductible
Endoscopies (e.g., colonoscopy or sigmoidoscopy) Colonoscopies limited to persons over age 50 and/or in accordance with AMA guidelines.	100%, deductible waived	Not Covered
Bone Density	100%, deductible waived	Not Covered
Vision Exam (solely to determine vision correction)	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Hearing Exam	Not Covered	Not Covered

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
SUPPLEMENTAL ACCIDENT		
Eligible charges Claims must be incurred within 90 days of accident	100%, deductible waived up to $300, then 80% after deductible	100%, deductible waived up to $300, then 50% after deductible

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
HOSPITAL SERVICES		
Room and Board *Benefits payable at the facility's semi-private room rate unless only a private room is available or is medically necessary*	80% after deductible	50% after deductible
Intensive Care Unit *Benefits payable at facility's ICU rate.*	80% after deductible	50% after deductible
Emergency Room for Medical Emergency only *(see defined terms section of this document)* Non-Emergency Use of the Emergency Room	80% after deductible 50% after deductible	50% after deductible 50% after deductible
Routine Well Newborn Care (Inpatient Care)	80% after deductible	50% after deductible
Inpatient Private Duty Nursing	Not Covered	Not Covered
Inpatient Prescription Drugs	80% after deductible	50% after deductible
Pre-admission Testing	80%; deductible waived	50%; deductible waived
Outpatient Hospital Services	80% after deductible	50% after deductible

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PHYSICIAN SERVICES		
Inpatient visits *(includes inpatient well newborn care)*	80% after deductible	50% after deductible

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PHYSICIAN SERVICES		
Emergency Room services for Medical Emergency only *(see defined terms section of this document)*	80% after deductible	50% after deductible
Non-Emergency Use of the Emergency Room	50% after deductible	50% after deductible
Office visit only - Primary Care Provider (PCP)	80% after deductible	50% after deductible
Office visit only – Specialist	80% after deductible	50% after deductible
Telemedicine visit	Same as Office Visit benefit	
Office visit services *These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.*	80% after deductible	50% after deductible
Office services (not associated with office visit) – no office visit charge *These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.*	80% after deductible	50% after deductible
Allergy testing	80% after deductible	50% after deductible
Injections (by Physician) *Includes allergy injections and serum*	80% after deductible	50% after deductible
Inpatient Surgery	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
Office Surgery	80% after deductible	50% after deductible
Oral Surgery	80% after deductible	50% after deductible
Extraction of Impacted Wisdom Teeth	80% after deductible	50% after deductible
Second Surgical Opinion	80%; deductible waived	50%; deductible waived
Endoscopies (non-routine)	80% after deductible	50% after deductible
Contraceptive Management		
Office Visit	80% after deductible	50% after deductible
Injections	80% after deductible	50% after deductible
Implants	80% after deductible	50% after deductible
Intrauterine Device	80% after deductible	50% after deductible
Diaphragm	80% after deductible	50% after deductible
Female condom	80% after deductible	50% after deductible
Over the Counter Contraceptives	Not Covered	Not Covered

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Testing for the 2019 Novel Coronavirus (COVID-19) *See limits in Medical Benefits section*	100%, deductible waived	100%, deductible waived
Ambulance Service	80% after deductible	80% after deductible
Skilled Nursing Facility *Benefits payable at the facility's semiprivate room rate. Calendar Year Maximum: 60 days*	80% after deductible	50% after deductible
Urgent Care Center	80% after deductible	50% after deductible

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Independent X-ray Services (i.e., not in Physician office or Hospital and non-routine) *Does not include MRI, MRA, CT Scans, PET Scans or DEXA scans*	80% after deductible	50% after deductible
Independent Laboratory Services (i.e., not in Physician office or Hospital and non-routine) *Does not include MRI, MRA, CT Scans, PET Scans or DEXA scans*	80% after deductible	50% after deductible
Labcorp	100%, deductible waived	Not applicable
MRI/MRA, CT/CTA Scan, PET Scan performed in free-standing diagnostic center	80% after deductible	50% after deductible
MRI/MRA, CT/CTA Scan, PET Scan performed in outpatient Hospital	80% after deductible	50% after deductible
Genetic Testing *Note: Genetic Tests are covered **only** if (1) they are Medically Necessary and meet the conditions listed in the Medical Benefits section of the Plan.*	80% after deductible	50% after deductible
Organ Transplants	80% after deductible	50% after deductible
Pregnancy *Pregnancies of Dependent children are not covered.*	100% after $250 copayment for inpatient hospital services, deductible waived 100% after $250 copayment for inpatient physician services, deductible waived All other charges related to pregnancy are subject to deductible and co-insurance.	50% after deductible
Sterilization	Not Covered	Not Covered
Impotence Diagnosis **Impotence Testing and Treatment**	80% after deductible Not Covered	50% after deductible Not Covered
Infertility Diagnosis **Infertility Testing and Treatment**	80% after deductible Not Covered	50% after deductible Not Covered
Outpatient Private Duty Nursing *Limited to 120 visits per Calendar Year*	80% after deductible	50% after deductible
Home Health Care *Calendar Year maximum: 120 visits*	80% after deductible	50% after deductible
Hospice Care *Calendar Year maximums: 30 inpatient days and 15 outpatient visits*	80% after deductible	50% after deductible
Occupational Therapy *Calendar Year maximum: 60 visits*	80% after deductible	50% after deductible
Speech Therapy	80% after deductible	50% after deductible
Physical Therapy *Calendar Year maximum: 60 visits*	80% after deductible	50% after deductible
Cardiac Rehabilitation Therapy	80% after deductible	50% after deductible
Chemotherapy	80% after deductible	50% after deductible
Radiation Therapy	80% after deductible	50% after deductible
Infusion Therapy	80% after deductible	50% after deductible
Jaw Joint/TMJ *Calendar Year Maximum: $1,000*	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible

PPO BASIC PLAN	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
OTHER SERVICES		
Injectables administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting	80% after deductible	50% after deductible
Diabetic Supplies	80% after deductible	50% after deductible
Diabetic Education	80% after deductible	50% after deductible
Autism	80% after deductible	50% after deductible
Wig After Chemotherapy *Lifetime maximum: 1 wig*	80% after deductible	50% after deductible
Prosthetics	80% after deductible	50% after deductible
Orthotics – foot	80% after deductible	50% after deductible
Orthotics – other	80% after deductible	50% after deductible
Hearing Aid	Not Covered	Not Covered
Pain Management	80% after deductible	50% after deductible
Spinal Manipulation Chiropractic *Calendar Year maximum: $500*	80% after deductible	50% after deductible
Attention Deficit Hyperactivity Disorder Treatment	80% after deductible	50% after deductible
Mental Disorders/Substance Abuse (combined)		
Inpatient *Benefits payable at the facility's semi-private room rate or ICU rate, as applicable.*	80% after deductible	50% after deductible
Partial Hospitalization	80% after deductible	50% after deductible
Outpatient	80% after deductible	50% after deductible
Office Visit	80% after deductible	50% after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE
BASE PLAN

Refer to the Prescription Drug section for details on the Prescription Drug benefits

PRESCRIPTION DRUG BENEFIT	
Prescription Drug Deductible Amount	**Included with medical**
Prescription Drug Out-of-Pocket Amount	**Included with medical**
Pharmacy Option (30 Day Supply)	
Generic Drugs	80% after deductible
Brand Name Drugs	80% after deductible
Mail Order Option (90 Day Supply)	
Generic Drugs	80% after deductible
Brand Drugs	80% after deductible

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. All Employees of the Employer.

Other Eligible Classes. Elected Officials and Appointed Magistrate Judges who are on Bulloch County's payroll; any Court Reporter performing services for the Ogeechee Judicial Circuit on or before January 1, 2000, so long as such Court Reporter remains an officially designated Court Reporter for one of the Superior Court Judges of the Ogeechee Judicial Circuit.

Unless otherwise indicated, a reference to Employee throughout this document shall include Elected Officials, Appointed Magistrate Judges, and Court Reporters as specified in the paragraph above.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time Employee of the Employer (an Employee is considered to be Full-Time if he or she is employed an average of at least 30 hours of service per week and is on the regular payroll of the Employer for that service; and

(2) completes the employment Waiting Period extending from the date of hire until the first day of the first calendar month following 30 consecutive days as a new Employee.

Under the Patient Protection and Affordable Care Act, employers are allowed to choose among various options to determine if an employee averages at least 30 hours of service per week. The Plan Administrator has implemented a policy using a 12-month look-back measurement period to determine if an Employee averages at least 30 hours of service per week. If an Employee averages at least 30 hours of service per week during a 12-month measurement period, then that Employee, if still employed, will be eligible for coverage for an entire 12-month stability period following the applicable measurement period. New employees who are expected to average at least 30 hours of service per week are eligible for coverage after completing the Waiting Period. This is a brief summary and does not address every detail and nuance of the measurement policy. Employees who wish to review the entire measurement policy may request a copy from the Plan Administrator.

Employees who are still employed by the Employer and were (i) previously covered by the Plan and lost coverage because they no longer met the eligibility requirements (i.e., lost Full-Time Employee status), or (ii) were previously ineligible for coverage because they did not meet the eligibility requirements (i.e., did not have Full-Time Employee status), will be eligible for coverage under the Plan during the applicable stability period if they subsequently regain or obtain Full-Time status during the applicable measurement period.

Coverage begins on the first day of the first calendar month following the date that the Employee satisfies all of the eligibility and enrollment requirements of the Plan.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages; provided, however, that if the Employee lives or was married in a state other than Georgia, the Employee's marriage must be recognized as valid under the laws of the state of Georgia. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption, or a Foster Child. An Employee's Child will be an eligible Dependent until the end of the calendar month in which the Child reaches the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the calendar month in which the child reaches the limiting age of 26.

The phrase "child placed with the Employee for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be unmarried, under the limiting age of 19 years, living with the Employee and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

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

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. Proof of Total Disability must be submitted to the Plan Administrator within 31 days of the date the child's coverage would have terminated due to age. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent, or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan for Employees. Bulloch County Board of Commissioners shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage includes a payroll deduction authorization which must be signed and returned as part of the enrollment application.

This Plan allows Employees to pay their contributions for health care coverage on a pre-tax basis. A portion of the Employees' compensation is deducted from their paycheck before their taxes are calculated. In this way, Employees pay for their health care coverage with pre-tax dollars and pay less in taxes.

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

If an Employee has coverage under the Plan, the Employee's newborn child will automatically be covered at birth for 31 days. In order for coverage to continue beyond 31 days, a newborn child must be enrolled and any required contributions must be paid within 31 days after birth. If the newborn child is not enrolled and required contributions are not made on a timely basis, coverage will terminate at the end of 31 days following the child's date of birth. Note: a claim for maternity expenses is not considered enrollment for a newborn child's coverage to continue beyond 31 days.

For newborns enrolled in the Plan, charges for covered routine Physician care, covered nursery care, and coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities, or complications resulting from prematurity will be applied toward the Plan of the newborn child.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous and the covered Employee enrolls the Dependent children within 31 days of the children's loss of coverage.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on July 1.

CHANGES IN PLAN ENROLLMENT

As discussed in the Funding section above, the Employer offers a premium conversion plan that allows Employees to make pre-tax contributions to this Plan. For this reason, covered Employees are generally not permitted to make a change in the Plan coverage options they elected at the initial enrollment period for a plan benefit year. However,

covered Employees may change their level of coverage if a covered Employee experiences a Special Enrollment event. See the Special Enrollment Periods section for information.

In addition to the Special Enrollment Periods described below, Internal Revenue Service regulations and rulings allow the Employer to permit employees to make changes in Plan coverage options outside the initial enrollment period under certain other circumstances ("Permissible Events"). If a covered Employee experiences a Permissible Event and wishes to change his or her level of coverage, he or she must submit an enrollment application to the Plan Administrator no later than 31 days after the effective date of the Permissible Event. The change in coverage must be on account of and correspond with the Permissible Event. The Plan Administrator reserves the right to require the Employee to submit proof of any Permissible Event at the Employee's expense. Unless otherwise provided below, coverage will become effective on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment application provided that the Employee has met all eligibility requirements of the Plan. For this Plan, the following are considered Permissible Events:

(1) When a change is made under another employer plan with a period of coverage that is different from the period of coverage under this Plan, the Employee may make a prospective election change that is on account of and corresponds with the change under the other employer plan. If the Employee submits the completed enrollment application to the Plan Administrator prior to the effective date of the change under the other employer plan, coverage will become effective on the effective date of the change under the other employer plan. If the Employee submits the completed enrollment application to the Plan Administrator within 31 days after the effective date of the change under the other employer plan, coverage will become effective on the first day of the first calendar month following submission of the completed enrollment application.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information, contact the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) Individuals losing other coverage. An Employee or Dependent who loses other coverage, and who is eligible for but not enrolled in this Plan, may enroll in this Plan if loss of eligibility for the other coverage is due to and complies with the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who lost the coverage was under COBRA and the COBRA coverage was exhausted, or the coverage was not under COBRA and was terminated either as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent must request enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

Coverage will begin on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment form.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Individuals losing Medicaid coverage or State Child Health Insurance Plan (CHIP) coverage. An Employee or Dependent who is eligible for but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

(a) The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage.

(b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of termination of the Medicaid or State child health plan coverage. Coverage obtained due to loss of Medicaid or CHIP coverage will be effective on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment request.

(3) Individuals becoming eligible for employment assistance under Medicaid coverage or CHIP coverage. An Employee or Dependent who is eligible for but not enrolled in this Plan, may enroll if each of the following conditions is met. However, if a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

(a) The Employee or Dependent becomes eligible for assistance, with respect to coverage under this Plan, under a Medicaid plan or State child health plan.

(b) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance. Coverage obtained due to assistance eligibility will be effective on the first day of the first calendar month following the date the Plan Administrator receives the completed enrollment request.

(4) Individuals becoming eligible as Dependents. A Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan in the following circumstances:

(a) If the Employee is a participant under this Plan or is eligible to be enrolled under this Plan, and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first calendar month following the date that the Plan Administrator receives the completed enrollment request;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Enrollment Requirements of the Plan.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

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

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes or ceases to be eligible for coverage under the Plan, including but not limited to the covered Employee's death or the termination of the covered Employee's employment, or a reduction in the covered Employee's hours of service; provided, however, that termination of coverage due to a reduction in hours of service will not become effective until the end of the covered Employee's current stability period. (See the section entitled Continuation Coverage Rights under COBRA for a complete

explanation of when COBRA continuation coverage is available, what conditions apply and how to select it.) It also includes an Employee on disability leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The last day of the calendar month for which the required contribution has been paid.

(4) If an Employee commits fraud, makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave (for example, because of the Employee's failure to pay his or her portion of the premium while on unpaid FMLA leave), coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Continuation During Authorized Leave of Absence. Coverage will continue during any authorized paid or unpaid leave of absence for up to 6 months. If it is a paid leave of absence, the covered Employee's required contribution will continue to be deducted from payroll. If it is an unpaid leave of absence, the covered Employee must pay the required contribution when due. If a covered Employee exhausts FMLA leave but continues to be on an authorized leave of absence, the period of time that the covered Employee was on FMLA leave will count toward the 6-month maximum for an authorized leave of absence.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements only if the Employee did not have an hour of service for a period of at least 13 consecutive weeks immediately preceding the resumption of services. Otherwise the rehired Employee will be treated as a continuing employee.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period will not be imposed in connection with the reinstatement of coverage upon reemployment; provided, however, that an exclusion will be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent and not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it.)

(3) In regard to a Dependent who is a covered Spouse, on the date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it.)

(4) In regard to a Dependent who is a covered Child, on the first date that the covered Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA for a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it.)

(5) The last day of the calendar month for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud, makes a material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect or terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage options are right for them.

Benefit choices made during the open enrollment period will become effective on July 1 following the end of the open enrollment period and remain in effect for the following year unless there is a Special Enrollment event. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one plan to another plan.

During the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective on July 1 following the end of the open enrollment period.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SUPPLEMENTARY ACCIDENT CHARGE BENEFITS

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

(1) the charge is for a service delivered within 90 days of the date of the accident; and

(2) treatment is completed within 12 months after the date of the accident.

BENEFIT PAYMENT

Benefits will be paid as described in the Schedule of Benefits. Charges over the maximum shown in the Schedule of Benefits or incurred more than 12 months after the date of the accident will be paid at the co-insurance percentage shown in the Schedule of Benefits after satisfaction of the applicable deductible.

MEDICAL BENEFITS

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

DEDUCTIBLE

Covered Person Deductible. This is an amount of Allowable Charges for which no benefits will be paid. When a Covered Person meets his or her Covered Person Deductible for a Calendar Year, then Allowable Charges for that Covered Person will be paid at the percentages shown in the Schedule of Benefits.

Deductible Three Month Carryover. Allowable Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the individual deductible (not the family deductible) in the next Calendar Year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

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

OUT-OF-POCKET MAXIMUM

After the Covered Person Deductible has been met, Allowable Charges for that Covered Person are payable at the percentages shown each Calendar Year until the out-of-pocket maximum for a Covered Person shown in the Schedule of Benefits is reached. Allowable Charges incurred by that Covered Person will then be payable at 100% for the rest of the Calendar Year. Allowable Charges do not include charges that are otherwise excluded under this Plan.

When a Family Unit reaches the out-of-pocket limit, Allowable Charges for that Family Unit will be payable at 100% for the rest of the Calendar Year. Allowable Charges do not include charges that are otherwise excluded under this Plan.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Allowable Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

COVERED CHARGES

Covered Charges are the following Medically Necessary items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished. Benefits are paid based on the Allowable Charge as defined in this Plan.

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

Room charges will be paid at the average private room rate if a hospital only has private rooms available or if a private room is medically necessary.

(2) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness and as stated in the Schedule of Benefits.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage of Pregnancy for a Dependent child.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable as stated in the Schedule of Benefits if and when:

(a) the patient is confined as a bed patient in the facility within 7 days of a Hospital confinement of at least 3 days; and

(b) the attending Physician certifies that the confinement is in lieu of a Hospital confinement and is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes and submits a written treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, and establishes that the service is Medically Necessary.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed through the same natural body opening, or through the same incision in the same operative field, benefits for the primary procedure will be determined based on the Allowable Charge for the primary procedure; benefits for additional procedures will be determined based on 50% of the Allowable Charge for each additional procedure performed during the same operative session. Any procedure for which an additional charge is not reasonable will be considered "incidental" and no benefits will be provided for such procedures; incidental procedures include, but are not limited to, incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, and simple repair of hiatal hernia.

(ii) If multiple unrelated surgical procedures are performed through separate body openings, or through separate incisions in separate operative fields, benefits will be based on the Allowable Charge for each independent surgical procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Allowable Charge.

Charges for second and third surgical opinions will be Covered Charges subject to the following provisions:

(i) If a Physician has recommended a surgical procedure covered by the Plan, the Covered Person may obtain a second opinion from another Physician regarding the surgical procedure.

(ii) If the second Physician's opinion does not confirm the original recommendation, the Covered Person may obtain a third opinion from another Physician regarding the surgical procedure.

(iii) Benefits for covered second and third opinions include the Physician's charges for the physical examination; and laboratory work, x-rays, and related tests not performed by the original physician.

(iv) Second and third opinions regarding cosmetic surgery, normal obstetrical delivery, and surgical procedures which require only local anesthesia are not covered under this benefit.

Charges for surgery performed at an outpatient surgical facility are Covered Charges and include miscellaneous services and supplies rendered by the facility on its own behalf; charges by a Physician rendered while the Covered Person is at the facility; x-rays; laboratory tests; radiology; and pathology. These are Covered Charges whether billed directly by the facility or separately by the Physician.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature.

(6) **Home Health Care Services and Supplies.** Charges for Medically Necessary home health care services and supplies will be paid as shown in the Schedule of Benefits, subject to the requirements and benefit maximums shown.

Charges are covered for the following services: (i) part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.); (ii) visits by persons who have completed a home health aide training course under the supervision of a Registered Nurse; (iii) Physical Therapy, Occupational Therapy, and Speech Therapy; and (iv) medical supplies, drugs and medications prescribed by a Physician, and laboratory services, to the extent such items would have been covered under the plan if the Covered Person had been hospitalized.

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

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan. The hospice care provider must meet standards set by the National Hospice Organization, and, if required by the state to be licensed, certified or registered, it must also meet that requirement. Hospice Care includes: (i) inpatient care in a hospice, Hospital, or home care setting; (ii) outpatient care, including drugs or medical supplies; and (iii) instructions for care of the patient, counseling, and other supportive services for the family of the dying individual.

(8) **Expenses associated with testing for COVID-19.** During the public health emergency related to COVID-19, all cost sharing (such as coinsurance, copayment, and deductible) is waived for in vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 ("COVID-19 tests") that (a) are approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, (b) for which the developer has requested or intends to request emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act unless and until such request is denied or is not submitted within a reasonable timeframe, (c) that are developed in and authorized by a State that notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19, (d) that the Secretary of Health and Human Services determines appropriate in guidance.

The Plan also waives any cost-sharing for (1) the administration of such diagnostic products and (2)

items and services furnished to a Covered Person during health care provider office visits (which include telehealth visits), urgent care center visits and emergency room visits that result in an order for or administration of such diagnostic products. The waiver of cost sharing for items and services in (2) above applies only to the extent the items and services relate to the furnishing and administration of the diagnostic products or to the evaluation of such Covered Person for purposes of determining the need of the Covered Person for such product.

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

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetics** and the administration of anesthesia by a licensed Anesthesiologist or certified Registered Nurse Anesthetist in connection with a covered surgical procedure when not covered as Hospital charges; oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment; blood and blood derivatives that are not donated or replaced, and the equipment for its administration; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with recovery from a myocardial infarction, coronary occlusion or coronary bypass surgery, or angina pectoris, but only when the diagnosis is established prior to the start date of the rehabilitation program as evidenced by a record of prior treatment; (c) except as provided below, initiated and completed within 12 weeks after a myocardial infarction, coronary occlusion or coronary bypass surgery, or a diagnosis of angina pectoris; and (d) in a Medical Care Facility as defined by this Plan.

In order for charges for cardiac rehabilitation which extend beyond 12 weeks following a myocardial infarction, or coronary occlusion or coronary bypass surgery (but not following a diagnosis of angina pectoris), to be considered as Covered Charges, medical documentation is required to establish that: (i) the patient is not on a maintenance exercise program; and (ii) continuation of the cardiac rehabilitation is necessary to enable the patient to reach an acceptable level of individual exercise tolerance consistent with the particular state of the patient's disease. Charges for cardiac rehabilitation for angina pectoris extending beyond 12 weeks after the diagnosis will be denied on the basis a monitored exercise program is no longer considered Medically Necessary for the treatment of the disease involved.

The Plan specifically excludes dietary instruction, educational services, behavior modification, literature, membership in health clubs, exercise equipment, preventive programs, and any other items otherwise specifically excluded under this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances; provided, however, that only chemotherapy treatment approved by the National Comprehensive Cancer Network or the Food and Drug Administration is covered by the Plan. The materials and services of technicians are included.

(e) Initial **contact lenses** or glasses required following cataract surgery.

(f) **Diabetic Education.** The Plan covers diabetic self-management education. Coverage is limited to visits for the diagnosis of diabetes, when a Physician diagnoses a significant change in the Covered Person's symptoms or conditions that necessitates changes in the Covered Person's self-management, or where reeducation or refresher education is necessary. Coverage includes home visits when Medically Necessary.

The diabetic education must be provided by a Physician or other licensed health care provider, or his or her staff, as part of an office visit for diabetes diagnosis or treatment, or by a certified diabetes nurse educator, certified nutritionist, certified dietitian or registered dietitian, upon the referral of a Physician or other licensed health care provider.

(g) Rental of **Durable Medical Equipment** or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

The Plan also covers necessary maintenance and repairs of purchased durable medical equipment and loaner equipment used while repairs are being made. Replacement is covered only if (i) the patient has experienced a change in his or her physiological condition, or (ii) required repairs would exceed the cost of a replacement device or the parts that need to be replaced, or (iii) there has been irreparable change in the device's condition or in a part of the device due to normal wear and tear.

(h) **Genetic tests** that are Medically Necessary and that meet the following conditions:

- the results will directly impact clinical decision making and/or clinical outcome for the individual;
- the testing method must be considered scientifically valid for identification of a genetically-linked heritable disease; and
- the individual either demonstrates signs/symptoms of a genetically heritable disease or has a direct risk factor (based on family history or pedigree analysis) for the development of a genetically linked heritable disease.

Genetic tests not meeting these criteria are not covered by the Plan.

(i) **Injectables** except as specifically excluded by the Plan or when given as treatment for a condition not covered by the Plan or in relation to services not covered by the Plan.

(j) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(k) **Laboratory studies.**

(l) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse.

A Mental Disorder must, according to generally accepted professional standards, be amenable to favorable modification. With the exception of Autism and Attention Deficit Hyperactivity Disorder, treatment must not extend beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation. No benefits are provided for court-ordered treatment of Mental Disorders or Substance Abuse. Treatment of Mental Disorders or Substance Abuse must be given under the direction of a Physician and the treatment program must be accredited by The Joint Commission or by equal standards.

(m) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

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

No charge will be covered under Medical Benefits for oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

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

(o) **Organ or tissue transplant.**

Benefits are payable for expenses incurred by a Covered Person for services and supplies required for any of the following human to human organ or tissue transplants: kidney, cornea, heart, heart/lung, liver, pancreas, bone marrow, and skin transplants.

When the recipient is a Covered Person, the Plan will cover donor organ or tissue charges for diagnostic services and supplies necessary to determine if the Covered Person is a suitable candidate for a transplant procedure, evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ to the place where the transplant is to take place. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. The Plan will always pay secondary to any other coverage.

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

(q) **Pain Management.**

(r) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Physical therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a covered benefit.

(s) **Prescription Drugs.**

(t) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

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

(v) **Reconstructive Surgery.** Correction of abnormal congenital conditions, restoration or provision of normal bodily functions lost as a result of Injury or Sickness, and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

Precertification and Utilization Review requirements of the Plan will not apply to surgical and treatment procedures associated with mastectomies of a Covered Person.

(w) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness other than a learning disorder. The patient must demonstrate functional gains; speech therapy for the sole reason of maintaining current level of functioning and to prevent deterioration is not a covered benefit.

(x) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. subject to the benefit maximum in the Schedule of Benefits.

(y) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(z) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth. Charges for covered routine nursery care will be applied toward the deductible of the newborn child.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the benefits of the newborn child.

(aa) Charges associated with the initial purchase of a **wig after chemotherapy.**

(bb) **Diagnostic x-rays and other tests**. Covered Charges include diagnostic x-rays; electrocardiograms; electroencephalograms; ultrasound; amniocentesis; and other laboratory and pathology tests prescribed by a Physician and performed as the result of a covered Injury or Sickness. The services of radiologists and pathologists are also covered.

(cc) **Sleep Disorder/Sleep Apnea.** Covered Charges include the diagnosis, care and treatment of sleep disorders/sleep apnea if it is deemed Medically Necessary.

(dd) **Autism.** Covered charges include charges for the care, testing, and treatment of Autism, which is a disorder of neural development characterized by impaired social interaction and communication, and by restricted and repetitive behavior.

(ee) **Attention Deficit Hyperactivity Disorder.** Covered Charges include charges for the care, testing, and treatment of Attention Deficit Hyperactivity Disorder, which is a psychiatric and neurobehavioral disorder characterized by either significant difficulties of inattention or hyperactivity and impulsiveness, or a combination of the two.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Utilization Management number on the member Identification Card.

The provider, patient, or family member must call this number to receive certification of certain services. This call must be made before services are rendered or within the earlier of 48 hours or the first business day after an emergency.

Any reduced reimbursement due to failure to follow utilization management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

Until the end of the public health emergency related to COVID-19, the Plan does not impose prior authorization or other medical management requirements for in vitro diagnostic products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 that are (a) approved, cleared, or authorized under the Federal Food, Drug, and Cosmetic Act, (b) for which the developer has requested or intends to request emergency use authorization under section 564 of the Federal Food, Drug, and Cosmetic Act unless and until such request is denied or is not submitted within a reasonable timeframe, (c) that are developed in and authorized by a State that notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19, (d) that the Secretary of Health and Human Services determines appropriate in guidance.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospital Admissions
Skilled Nursing Facility Admissions
Outpatient Surgery
Inpatient Mental Disorders and Substance Abuse Treatment

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

Prior authorization (precertification of services) is not a guarantee of coverage. The utilization management program is designed only to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the utilization management program will increase benefits to cover any confinement or service which is not Medically Necessary or which is otherwise not covered under the Plan.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a Hospital length of stay in connection with childbirth for the mother or her newborn child that is 48 hours or less following a vaginal delivery or 96 hours or less following a cesarean delivery.

Obstetric hospitalizations that exceed the 48 or 96 hour time periods and any services that are not associated with the delivery must be precertified as set forth in this document.

NOTE: When the delivery occurs outside a Hospital, the Hospital length of stay begins at the time the mother or newborn is admitted as a Hospital inpatient in connection with childbirth. The attending Physician will determine whether the admission is in connection with childbirth.

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

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization management program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the Medical Management Administrator at the telephone number on the Covered Person's ID card **before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Employee identification number, and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the Medical Management Administrator on the earlier of 48 hours or the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

The Covered Person is ultimately responsible for obtaining required authorization for services. To minimize the risk of reduced benefits, the Covered Person should contact the Medical Management Administrator to make certain that the facility or attending Physician has initiated the necessary precertification process. If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50% up to a maximum of $500. The penalty for failure to precertify inpatient admissions will apply only to the facility charge for the inpatient stay.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

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

PREADMISSION TESTING SERVICE

Benefits for diagnostic lab tests and x-ray exams are payable when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

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

DEFINED TERMS

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

Allowable Charge is the amount of a Provider's billed Covered Charges used by the Plan to determine the benefits that are payable for a Plan Participant. The Allowable Charge may be the contracted rate (for network providers), an amount agreed upon between the Plan and Provider that may be less than the Usual and Reasonable Charge (for out-of-network providers) , or the Usual and Reasonable Charge (for out-of-network providers).

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

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

Certified Nurse Midwife means a person who has been certified as a Nurse Midwife by the American College of Nurse Midwives and who is authorized to practice as a Nurse Midwife under the state regulations where the Covered Person receives the services.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is on the regular payroll of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship, and who has begun to perform the duties of his or her job with the Employer. Part-time Employees and Retired employees are not eligible for coverage under this Plan. The following persons are also not eligible for coverage under this Plan: (i) leased employees as defined in Internal Revenue Code section 414(n)(2); (ii) individuals classified by the Employer as independent contractors or leased employees (including those who are at any time reclassified as employees by the Internal Revenue Service or a court of competent jurisdiction).

Employer is Bulloch County Board of Commissioners.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Essential Health Benefits means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered with these categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease managements; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific treatments. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles which, if applicable, indicate that it is Experimental and/or Investigational:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or I investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

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

However, the use of FDA-approved chemotherapy drugs or agents to treat a cancer for which the drugs or agents are not approved treatment by the FDA, and for which there is no Reliable Evidence of the safety and efficacy of the treatment, will not be considered Experimental or Investigational if the chemotherapy drugs or agents are approved by the National Comprehensive Cancer Network.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications of safe, effective therapeutic drugs specifically covered by this Plan.

Foster Child means a child who meets the eligibility requirements shown in the Dependent Eligibility section of this Plan for whom a covered Employee has assumed a legal obligation in connection with the child's placement with a state, county, or private foster care agency.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic Information does not include information about the age or gender of an individual.

Grandfathered Plan. Group health plans existing on March 23, 2010, are "grandfathered" under the ACA. These plans are deemed to be "minimum essential coverage," have special effective date rules for certain health reform changes and are completely exempt from certain other changes. A grandfathered plan is allowed to enroll new employees (both newly hired and newly enrolled) and their families without losing its grandfathered status. However, grandfathered status would be lost if various actions were taken with respect to the plan (such as changing insurance carriers, eliminating benefits, raising percentage cost-sharing requirements, significantly raising fixed-amount cost-sharing or co-payment requirements, significantly lowering employer contributions, imposing new or decreased annual dollar limits, etc.).

Health Factor means, in relation to an individual, any of the following health status-related factors: (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) Genetic Information; (vii) evidence of insurability (including conditions arising out of domestic violence); or (viii) disability.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and that is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons whose life expectancy is six months or less.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Except with regard to a covered Dependent other than a Spouse, Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means a physical Injury to the body caused by external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from Illness, Injury (whether or not the Injury is accidental), Pregnancy, or congenital malformation. However, Genetic Information is not a Medical Condition.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part. It also means a situation in which a Covered Person appears to have a mental or emotional disorder for which immediate observation, care, and treatment is necessary to avoid serious harm to the Covered Person or others.

Medical Necessity means care or treatment that is Medically Necessary.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary, must be no more costly than alternative interventions (including no intervention) and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Sickness or Injury without adversely affecting the Plan Participant's medical condition.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on the above criteria.

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

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

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

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

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

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

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist Doctor of Dental Medicine (D.M.D.), Optometrist (O.D.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Bulloch County Board of Commissioners Employee Health Care Plan, which is a benefits plan for certain Employees of Bulloch County Board of Commissioners and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

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

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Primary Care Provider is a Network Provider physician with a specialty of internal medicine, pediatrics, obstetrics/gynecology, or family medicine/general practice who provides initial and primary care services to Covered Persons, maintains the continuity of Covered Person's medical care, and helps direct Covered Persons to Specialists and other health care providers.

Sickness means the following:

(1) **For a covered Employee and covered Spouse:** Illness, disease or Pregnancy.

(2) **For a covered Dependent other than Spouse**: Illness or disease, not including Pregnancy or its complications.

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

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

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

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

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Specialist is a health care practitioner who has received training in a specific medical field other than the specialties listed as primary care.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation

in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Employee, the complete inability to perform all the essential functions of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer or its designee.

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

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply to individuals with similar medical conditions for a given procedure, and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

For out-of-network providers, the Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator will determine the Usual and Reasonable Charge based on nationally obtained and recognized survey data.

PLAN EXCLUSIONS

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

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

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy.

(2) **Artificial Heart.** Expenses related to insertion or maintenance of an artificial heart. Artificial cardiac pacemakers and other similar medical devices are covered as deemed medically necessary

(3) **Acupuncture.** Charges for acupuncture.

(4) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(5) **Autopsy.** Charges for services associated with autopsy or postmortem examination, including the autopsy.

(6) **Biofeedback**. Charges for biofeedback, holistic medicine, or other forms of self-care or self-help.

(7) **Completion of claim forms** or preparation of medical reports; for missed appointments.

(8) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(9) **Co-payments, deductibles and out-of-pocket maximums.** Charges for prescription drug co-payments or expenses used to satisfy plan deductibles or out-of-pocket maximums.

(10) **Court-ordered treatment.** Court ordered treatment or testing, unless Medically Necessary and approved by the Plan Administrator.

(11) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, whether or not recommended by a physician.

(12) **Educational or vocational testing.** Services for educational or vocational testing or training. Diabetic training, education or nutritional therapy which is ordered by a physician will be considered an allowable expense.

(13) **Employment, Insurance, or License related care.** Physical exams or immunizations or any other treatment required for enrollment in any insurance program, as a condition of employment, for licensing, or other similar purposes.

(14) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

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

(16) **Experimental, Cosmetic, or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary (such as care or treatment for services that are

cosmetic (i.e., procedures or services that change or improve appearance without significantly improving physiological function)). However, reconstructive surgery that is (a) necessary to correct a deformity or (b) necessary to restore or provide normal bodily function lost as a result of an injury or illness or (c) due to a congenital disease or anomaly which has resulted in a functional defect of a covered Dependent Child or (d) expressly covered by the Plan such as reconstructive mammoplasty following mastectomy, is covered.

(17) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye exams for vision correction, including refractions, and eyeglasses and contact lenses and exams for their fitting. Provided, however, that contact lenses prescribed by an ophthalmologist in connection with the treatment of cataracts are covered. This exclusion also does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

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

(19) **Foreign travel.** Care, treatment or supplies out of the U.S. or its territories, except for an Injury or Medical Emergency. Also excluded is care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(20) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(21) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(22) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(23) **Home or vehicle modifications.**

(24) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(25) **Hypnosis. Charges for hypnosis.**

(26) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(27) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(28) **Impotence.** Care, treatment, testing, services, supplies, or medication for impotence.

(29) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. Charges related to the diagnosis of infertility are covered.

(30) **Maintenance care.** Maintenance care, which consists of services and supplies furnished mainly to maintain rather than improve a level of physical or mental function or to provide a protected environment free from exposure that can worsen the Covered Person's physical or mental condition.

(31) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

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

(33) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with medical advice or is discharged from a Hospital or Skilled Nursing Facility against medical advice; also charges for services from a Hospital or Skilled Nursing Facility for a Covered Person who remains in the Hospital or Skilled Nursing Facility after the attending Physician advises that further services from the Hospital or Skilled Nursing Facility are not Medically Necessary.

(34) **Non-Medical Emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday, Saturday or Sunday. This does not apply if surgery is performed within 24 hours of admission.

(35) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(36) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(37) **Not specified as covered.** Non-traditional or any other medical services, treatments and supplies which are not specified as covered under this Plan.

(38) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

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

(40) **Off-label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses. However, the use of chemotherapy drugs or agents to treat a cancer for which the drugs or agents are not approved treatment by the FDA will be covered by the Plan if the chemotherapy drugs or agents are approved by the National Comprehensive Cancer Network.

(41) Treatment of **Paraphillia** (exhibitionism, fetishism, pedophilia, sexual masochism, sexual sadism, transvestic fetishism, voyeurism).

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

(43) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(44) **Pregnancy of daughter.** Care and treatment of Pregnancy and complications of Pregnancy for a dependent daughter only.

(45) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(46) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(47) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

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

(49) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(50) **Sex changes, sex counseling, and sexual or gender dysfunctions or inadequacies.** Care, services or treatment for non-congenital transsexualism, gender dysphoria, sexual reassignment or change, and sexual or gender dysfunctions or inadequacies. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(51) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary. Diagnostic testing for sleep disorders is covered.

(52) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

(53) **Surgical sterilization or reversal.** Care and treatment for surgical sterilizations or their reversal.

(54) **Surrogate parenting or adoption expenses.** Charges for the services of a surrogate mother or for adoption expenses.

(55) **Therapies.** Massage therapy unless applied in conjunction with other active physical therapy modalities for a specific Illness or Injury, music therapy, vision therapy, aquatic therapy, or remedial reading therapy. Also excluded are charges for sex therapy, hypnotherapy; diversional, recreational, or educational therapies (such as hobbies, arts and crafts, dance) and any related testing; primal or perceptual therapy; or milieu therapy primarily directed toward self-enhancement or to change or control one's environment.

(56) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge or as otherwise specified as covered in this document; charges for travel time and related expenses by an eligible provider of services.

(57) **War.** Any loss that is due to a declared or undeclared act of war.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Copayments

The copayment is applied to each covered pharmacy drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc., as defined by the Prescription Benefit Manager). This service provides a convenient and cost effective method of obtaining 90-day supplies of medications and offers Covered Persons significant savings on their covered prescriptions.

Clinical Prior Authorization, Step Therapies, and Quantity Level Limitations

To ensure prescriptions are used appropriately, certain medications may require approval or "Prior Authorization."

To improve the quality of care of all Plan Participants, step care programs may be instituted for certain drug categories. Step therapies ensure medication usage is supported by national clinical guidelines and promotes the safe and appropriate use of prescription drugs.

The use of certain quantity level limitations may be implemented to assist in controlling overuse~~,~~ **or** abuse~~,~~ of specific medications by limiting the quantity of specific medications or therapeutic classes.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician, and injectable and non-injectable chemotherapeutic drugs.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Compounded drugs** that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and require a prescription order or refill. Compounded drugs that are available as a similar commercially available prescription drug product.

(4) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal. Retin-A is covered for Covered Persons under 20 years of age.

(7) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(8) **FDA.** Any drug not approved by the Food and Drug Administration.

(9) **Fluoride Preps & Washes**

(10) **Growth hormones for Covered Persons aged 20 and over.** Charges for drugs to enhance physical growth or athletic performance or appearance are covered only for Covered Persons through age 19 .

(11) **Immunization.** Immunization agents or biological sera, serums, toxoids, vaccines, allergens.

(12) **Impotence.** A charge for impotence medication.

(13) **Infertility.** A charge for infertility medication.

(14) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(15) **Intrauterine Devices.** Note that these are covered under the medical plan**.**

(16) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(17) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(18) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(19) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(20) **Off-label drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses. However, the use of chemotherapy drugs or agents to treat a cancer for which the drugs or agents are not approved treatment by the FDA will be covered by the Plan if the chemotherapy drugs or agents are approved by the National Comprehensive Cancer Network.

(21) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(22) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

DENTAL BENEFITS

Dental Benefits are elected separately from Medical Benefits and require payment of a separate premium. However, other provisions of this Plan may be involved in the administration of Dental Benefits as applicable.

SCHEDULE OF BENEFITS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, treatment, test or any other aspect of Plan benefits or requirements.

DENTAL BENEFITS

Calendar Year deductible,
Per covered person..... $ 50.00
Per Family Unit $150.00

The deductible applies to these Classes of Service:
Class B Services - Basic
Class C Services - Major

Dental Percentage Payable

Class A Services-
Preventive..... 100%

Class B Services-
Basic..... 80%

Class C Services-
Major 50%

Note: No benefits are payable for Class B Services that commence in the first 6 months of the Covered Person's coverage under the Plan. No benefits are payable for Class C Services in the first 12 months of the Covered Person's coverage under the Plan

Maximum Benefit Amount

Per Covered Person per Calendar Year..... $ 1,250.00

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances, or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

NOTE: Benefits for crowns are determined on the seat date.

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar year.

(2) One bite-wing x-ray series every 2 Calendar years.

(3) One full mouth x-ray every 5 Calendar years

(4) Other diagnostic x-rays as needed.

(5) One fluoride treatment for covered Dependent children under age 19 each Calendar Year.

(6) Space maintainers for covered Dependent children under age 19 to replace primary teeth.

(7) Emergency palliative treatment for pain.

(8) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 16, once per tooth per Lifetime.

Class B Services:
Basic Dental Procedures

(1) Oral surgery. Oral surgery is limited to removal of teeth (other than removal of wisdom teeth or bony impacted teeth, which are covered under the medical plan), preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(2) Periodontics (gum treatments). This includes periodontal examinations, periodontal maintenance care, and full mouth debridement.

(3) Endodontics (root canals).

(4) Extractions. This service includes local anesthesia and routine post-operative care.

(5) Recementing bridges, crowns or inlays.

(6) Fillings, other than gold.

(7) General anesthetics, upon demonstration of Medical Necessity.

(8) Antibiotic drugs.

(9) Pathology and diagnostic laboratory services performed to assist in the diagnosis of oral disease.

(10) Stainless steel crowns.

Class C Services:
Major Dental Procedures

(1) Gold restorations, including inlays, on-lays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation and replacement of crowns. Replacement of an existing crown is covered only if the crown is at least five (5) years old.

(3) Installing precision attachments for removable dentures.

(4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during 6 months following the installation. The Plan will not cover the initial placement of full or partial dentures to replace teeth that were missing before the Covered Person's Effective Date of coverage, unless the full or partial dentures also include replacement of a natural tooth extracted while the Covered Person is covered under this Plan.

(5) Addition of clasp or rest to existing partial removable dentures.

(6) Initial installation of fixed bridgework to replace one or more natural teeth that were extracted while the person was covered for these benefits. The Plan will not cover the initial placement of fixed bridgework to replace teeth that were missing before the Covered Person's Effective Date of coverage, unless the fixed bridgework also includes replacement of a natural tooth extracted while the Covered Person is covered under this Plan.

(7) Repair of crowns, bridgework and removable dentures.

(8) Re-basing or relining of removable dentures.

(9) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $200 or more, a predetermination of benefits form must be submitted.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Covenant Administrators, LLC
2810 Premiere Parkway, Suite 400
Duluth, GA 30097
678-258-8230

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fee are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Appliances.** Items intended for sport or home use, such as athletic mouth guards or habit-breaking applicances.

(3) **Before coverage.** (a) Care, treatment, or supplies for which a charge was incurred before a person was Covered under this Plan or before a person was Covered for a Class of Services under this Plan; or (b) care or treatment that commenced before a person was Covered under this Plan or before a person was Covered for a Class of Services under this Plan (i.e., an appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge, or gold restoration for which the tooth was prepared before the patient was covered; root canal therapy if the pulp chamber was opened before the patient was covered).

(4) **Bleaching** or whitening of teeth**.**

(5) **Bonding** of teeth.

(6) **Broken appointments.** Charges for broken or missed dental appointments.

(7) **Cosmetic Dentistry.** Treatment rendered for cosmetic purposes, except when necessitated by Injury or Sickness not caused or contributed to by engaging in felonious behavior (see exclusion (10) below).

(8) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.

(9) **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(10) **Felonious behavior**. Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.

(11) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(12) **Grafting.** Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

(13) **Hygiene.** Oral hygiene, plaque control programs, dietary instructions, or infection control.

(14) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(15) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan

(16) **Myofunctional Therapy.** Muscle training therapy or training to correct or control harmful habits.

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

(18) **No listing.** Services which are not included in the list of covered dental services.

(19) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(20) **Not Medically Necessary.** Care and treatment that is not Medically Necessary

(21) **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.

(22) **Orthodontia and Orthognathic surgery**. Orthodontic treatment and surgery to correct malpositions in the bones of the jaw.

(23) **Personalization.** Personalization of dentures.

(24) **Plan design.** Charges excluded or limited by the Plan design as stated in this document.

(25) **Relative.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(26) **Replacement.** Replacement of lost or stolen appliances.

(27) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane.

(28) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(29) **TMJ.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

(30) **War.** Any loss that is due to a declared or undeclared act or war.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Processor or Plan Administrator, as applicable, decides in its discretion that a Covered Person is entitled to them based on the provisions of the Plan.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Human Resources Department or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Processor at the address indicated on the member Identification Card.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Processor within one year of the date charges for the services were incurred. Claims filed later than that date may be declined or reduced. Benefits are based on the Plan's provisions at the time the charges were incurred.

Any corrections to a claim previously submitted must also be filed with the Claims Processor within 60 days after the date of the claim determination.

The Claims Processor will determine if enough information has been submitted to enable proper consideration of the claim. If not, the claim will be denied pending submission of additional information. Any information requested by the Claims Processor to process the claim must be submitted to the Claims Processor within 45 days after the date the claim is denied. Claims may remain denied if requested information is not received within 45 days after the date the Claims Processor notified the claimant of insufficient information to process the claim.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination."

A claimant is a Plan participant or beneficiary. Providers of medical service are not claimants unless specifically appointed in writing as the claimant's representative. However, the Plan will reply to requests for reconsideration from medical providers that are made in a timely manner (see Provider Reconsideration Requests below).

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Processor must decide whether to approve or deny the Claim. The Claims Processor's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Processor needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Processor must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

If you have any questions regarding this procedure, please contact the Plan Administrator.

NOTE: A second or subsequent submission of a claim that is for the same services to the same Plan participant provided by the same medical care provider on the same date of service as a claim submitted previously is not considered a new claim. Therefore, these claims will be processed as duplicate claims and will not entitle the claimant or provider to new or additional appeal rights.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours

Notification to claimant of insufficient information	24 hours
Response by claimant following notice of insufficient information	48 hours
Notification to claimant of benefit determination after having notified claimant of insufficient information	48 hours after the earlier of the receipt of information or the end of the claimant's response period.

Ongoing courses of treatment involving Urgent Care:

Notification to claimant of reduction or termination of treatment before the end of course of treatment	24 hours
Notification to claimant of benefit determination or of insufficient information in response to claimant's request to extend the course of treatment	24 hours
Response by claimant following notice of insufficient information	48 hours
Notification to claimant of benefit determination after having notified claimant of insufficient information	48 hours after the earlier of the receipt of information or the end of the claimant's response period.

Appeals of Adverse Benefit Determinations involving Urgent Care:

Filing of appeal by claimant	Within 180 days after receiving notice of Adverse Benefit Determination
Notification to claimant of decision on appeal	As soon as possible but no later than 15 days from receipt of appeal

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. 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.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination or of insufficient information	15 days
Extension due to matters beyond the control of the Plan	15 days
Response by claimant following notice of insufficient Information	45 days

Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Appeals of Adverse Benefit Determinations involving Pre-Service Claims	
Filing of appeal by claimant	Within 180 days after receiving notice of Adverse Benefit Determination
Notification to claimant of decision on appeal	15 days from receipt of appeal
Ongoing courses of treatment:	
Notification to claimant of reduction or termination of treatment before the end of course of treatment	Notification will allow time to finalize appeal before reduction or termination of treatment
Notification to claimant of benefit determination or of insufficient information in response to claimant's request to extend course of treatment	15 days
Extension due to matters beyond the control of the Plan	15 days
Response by claimant following notice of insufficient information	45 days
Appeals of Adverse Benefit Determinations involving ongoing courses of treatment:	
Filing of appeal by claimant	Within 180 days after receiving notice of Adverse Benefit Determination
Notification to claimant of decision on appeal	15 days from receipt of appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

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

Appeals of Adverse Benefit Determinations involving Post-Service Claims:	
Filing of appeal by claimant	Within 180 days after receiving notice of Adverse Benefit Determination
Notification to claimant of decision on appeal	15 days from receipt of appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures.

(5) If the Adverse Benefit Determination was based on an internal or external rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(6) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(7) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(8) If the Claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you not later than three days after the oral notification.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written appeal of the decision with the Plan Administrator. A claimant may submit written comments, documents, records, and other information relating to the Claim. The claimant must file his or her written appeal by mailing or hand delivering it to the Plan Administrator's Human Resources Department at the following addresses:

For mail: Bulloch County Board of Commissioners
P.O. Box 347
Statesboro, Georgia 30459
Attn: Human Resources Department

For hand delivery: Bulloch County Board of Commissioners
115 North Main Street
Statesboro, Georgia
Attn: Human Resources Department

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A statement of the claimant's right to review (on request and at no charge) relevant documents and other information.

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(5) If the Adverse Benefit Determination was based on an internal or external rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(6) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Any suit for benefits must be brought within two years after the date the Plan Administrator (or his or her designee) has made a final denial (or deemed denial) of the claim.

Provider Reconsideration Requests

When a provider of medical service receives a copy of the adverse benefit determination, the provider may request a reconsideration of the decision. The request must be in writing and must be sent to the Claims Administrator (attention Appeals Unit) within 180 days after the date of the determination. The request must include the claim number, the reason for the request (i.e., an explanation of why the provider thinks the claim was processed incorrectly), and supporting documentation that was not included with the initial claim submission. Provider reconsideration requests sent later than 180 days after the date of the determination will not be considered. A Provider does not have the same rights as a Claimant.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

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

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

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

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

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

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off

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

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

(d) When a child is covered as a Dependent and the parents are married, these rules will apply:

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

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

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

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

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

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

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established by judicial decree or some other means authorized by law.

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law.

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

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

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

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

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid Plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same items or services, payment under the Plan will be made in accordance with any state law which provides that the State has acquired the rights with respect to such individual to payment for such items and services under this Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical charges due to Injuries that may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical charges. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical charges, attorney fees, or other costs and expenses. The Plan does not share in the cost of the Covered Person's recovery. Accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical expenses from the Covered Person. Also, the Plan's rights to Subrogation and Refund still apply if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's rights of Subrogation and Refund as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the rights of the Plan to Subrogate or be reimbursed.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys'

fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Bulloch County Board of Commissioners, 115 North Main Street, Statesboro, GA 30458, (912) 764-6245. COBRA continuation coverage for the Plan is administered by Covenant Administrators, LLC, 2810 Premiere Parkway, Suite 400, Duluth, GA 30097, (678) 258-8230. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

When a person becomes eligible for COBRA, the person may also become eligible for other coverage options that may cost less than COBRA continuation coverage. **Medical Plan Participants may have other options available to them when they lose group health coverage.** For example, a person may be eligible to buy an individual Medical Plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, a person may qualify for lower costs on monthly premiums and lower out-of-pocket costs. Additionally, a person may qualify for a 30-day special enrollment period for another group health plan for which the person is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. To learn more about other options besides COBRA continuation coverage, visit www.healthcare.gov.

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

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

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

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. ***The Employee must enroll the child in the Plan by submitting an Enrollment Form (available from the COBRA or Plan Administrator) to the COBRA Administrator within thirty days after the birth or adoption.*** If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

Qualified Beneficiary by virtue of the relationship to the individual. A Domestic Partner is not a Qualified Beneficiary.

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

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

(1) The death of a covered Employee.

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

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

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

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

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

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

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

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

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified

beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

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

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

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

Can a person enroll in Medicare instead of COBRA continuation coverage after his or her group health plan coverage ends? In general, if a person doesn't enroll in Medicare Part A or B when he or she is first eligible because he or she is still employed, after the Medicare initial enrollment period, the person has an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

See https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods. These rules are different for people with End Stage Renal Disease (ESRD).

If a person doesn't enroll in Medicare and elects COBRA continuation coverage instead, he or she may have to pay a Part B late enrollment penalty and may have a gap in coverage if the person decides he or she wants Part B later. If a person elects COBRA continuation coverage and later enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate the continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if a person enrolls in the other part of Medicare after the date of the election of COBRA coverage.

If a person is enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if a person is not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the Qualified Beneficiary must notify the Plan Administrator or its designee in writing within 60 days after the later of the date the Qualifying Event occurs or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

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

Mail should be sent to the following address:

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458
Attn: Human Resources Department

Hand delivery should be made to the following address:

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458
Attn: Human Resources Department

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

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

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

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

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

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

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

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

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

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

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

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

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

The Qualified Beneficiary must notify the COBRA Administrator in writing within 30 days after the Qualified Beneficiary becomes covered by another group health plan or entitled to Medicare. The Qualified Beneficiary must also notify the COBRA Administrator in writing within 30 days after the date of the final determination by the Social Security Administration that the Qualified Beneficiary is no longer disabled. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries and the date on which the other coverage (or Medicare) became effective, or the date of the non-disability determination (as applicable).

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

fraudulent claim.

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

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

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the date coverage is lost due to the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. Also, these events can be a second Qualifying Event only if they would have caused the Qualified Beneficiary to lose coverage under the Plan if the first Qualifying Event had not occurred. For example, in most cases a former employee's entitlement to Medicare will not extend the 18-month COBRA continuation coverage period for the employee's spouse and dependents. This is because if the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), entitlement to Medicare would not result in a loss of family coverage under the Plan. By contrast, the divorce of the employee and spouse after the first qualifying event generally will extend the COBRA continuation coverage period for the spouse. If the employee had not terminated employment or reduced working hours (i.e., if the first qualifying event had not occurred), the divorce would result in a loss of coverage for the spouse.

In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date coverage is lost due to the first Qualifying Event. ***The Qualified Beneficiary must send written notice of the second Qualifying Event to the COBRA Administrator within 60 days after the later of the date of the Qualifying Event or the date coverage would be lost due to the Qualifying Event. This written notice must include the names and Plan identification numbers of the Qualified Beneficiaries, the type of Qualifying Event, and the date on which the Qualifying Event occurred.***

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is

determined under Title II or XVI of the Social Security Act to have been disabled at any time before the 60th day of COBRA continuation coverage. ***To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with written notice of the disability determination (including a copy of the determination) on a date that is both within 60 days after the later of the date of the determination or the date coverage is lost due to the Qualifying Event, and before the end of the original 18-month maximum coverage.***

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

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

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

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

PRIVACY AND SECURITY OF MEDICAL INFORMATION

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Bulloch County Board of Commissioner's workforce are designated as authorized to receive Protected Health Information from Bulloch County Board of Commissioner's Employee Health Care Plan ("the Plan") in order to perform their duties with respect to the Plan: County Administrative Officers, Human Resources Department, Chief Financial Officer, and Legal Counsel.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Bulloch County Board of Commissioners Employee Health Care Plan is the benefit plan of Bulloch County Board of Commissioners, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by Bulloch County Board of Commissioners to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Bulloch County Board of Commissioners shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

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

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Processor to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

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.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Processor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. However, the Plan will not retroactively terminate coverage due to a clerical error. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CONFORMITY WITH LAW

This Plan shall be deemed automatically amended to conform with minimum requirements of the Employee Retirement Income and Security Act ("ERISA") as may be amended from time to time. If any provision of this Plan conflicts with any other law to which it is subject, such provision shall be deemed automatically amended to conform to the minimum requirements of any such 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.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health and disability Plan and the claims administration is provided through a Third Party Claims Processor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Bulloch County Board of Commissioners Employee Health Care Plan

PLAN NUMBER: 501

TAX ID NUMBER: 58-6000789

PLAN EFFECTIVE DATE: July 1, 2010, amended and restated effective April 1, 2021

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458
(912) 764-6245

PLAN ADMINISTRATOR

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458

NAMED FIDUCIARY

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458

AGENT FOR SERVICE OF LEGAL PROCESS

Bulloch County Board of Commissioners
115 North Main Street
Statesboro, GA 30458

CLAIMS PROCESSOR

Covenant Administrators, LLC
2810 Premiere Parkway, Suite 400
Duluth, GA 30097
678-258-8230

BY THIS AGREEMENT, Bulloch County Board of Commissioners Employee Health Care Plan is hereby adopted as shown. It is agreed that the provisions set forth in this document and properly executed amendments hereto will be the basis for the administration of the Plan effective April 1, 2021.

IN WITNESS WHEREOF, this instrument is executed for Bulloch County Board of Commissioners on or as of the day and year first below written.

By Roy Thompson
Roy Thompson (Mar 18, 2021 08:41 EDT)
Bulloch County Board of Commissioners

Date Mar 18, 2021

Witness Missy Hagan
Missy Hagan (Mar 18, 2021 08:50 EDT)

Date Mar 18, 2021