PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR NACOG EMPLOYEE BENEFIT PLAN

DOCUMENT CONTAINS CONFIDENTIAL PROPRIETARY OR TRADE SECRET INFORMATION

NACOG EMPLOYEE BENEFIT PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of the NACOG Employee Benefit Plan, which is a form of a group health plan sponsored and maintained by Northern Arizona Council of Governments. The terms of this Summary Plan Description are effective as of January 1, 2015, and govern the administration and payment of claims Incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the Plan.**

GRANDFATHERED STATUS

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 that law was enacted. Being a grandfathered health plan means that your 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 Northern Arizona Council of Governments, 119 East Aspen Avenue, Flagstaff, AZ 86001-5222. You 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. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTE: Coverage for dental benefits is elected separately from coverage for medical benefits; the dental benefits included in this Plan are considered "excepted benefits" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

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HIGHLIGHTS OF THE NACOG EMPLOYEE BENEFIT PLAN

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

Eligible Employee

The term "Eligible Employee" shall mean a regular or probationary employee who worked or is regularly scheduled to work at least 25 hours a week for the Employer and who has completed a waiting period of 60 consecutive days on payroll while employed.* An employee is not a leased employee or an independent contractor. If an employee is out on leave without pay during the 60 day waiting period, the Plan adjusts the 60 days equal to the time the employee was out, regardless of the reason. At no time will coverage begin later than 90 days after an employee meets the Plan's definition of an Eligible Employee.

*If at a time other than date of hire, an employee moves ***from***: working or being regularly scheduled to work less than 25 hours per week ***to***: working or being regularly scheduled to work at least 25 hours a week, the waiting period will begin on the date the employee works or becomes regularly scheduled to work at least 25 hours a week.

In accordance with the Patient Protection and Affordable Care Act as well as IRS rules and guidelines in the Internal Revenue Code, Section 4980H (as amended), the Plan may use a Monthly Measurement Method or a Look-Back Measurement Method, or a combination of the two methods for determining the full-time status of employees. All New Employees who are not expected to work full-time at the time of hire, including variable hour and seasonal workers, may be subject to an Initial Measurement Period not to exceed twelve months.

If the Look-Back Measurement Method is used, then the term "Eligible Employee" shall also include a Variable Hour Employee who has averaged at least thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, or Administrative Period (if applicable), as determined by the Plan Sponsor. An employee who continues employment during the Stability Period will remain eligible throughout the Stability Period and Administrative Period (if applicable), regardless of a change in employment status (including, but not limited to, a reduction in hours).

For details and information about the Measurement Periods and, if applicable, Stability Periods and Administrative Periods, see your Personnel or Human Resources department.

The Plan Administrator determines status as an Eligible Employee hereunder.

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term "Eligible Dependent" shall mean any one or more of the following except that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first.

   A common law spouse is not eligible for coverage under the Plan, even in a state where common law marriage is recognized. A Domestic Partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee who is:

   a. under the age of 26; or

   b. Your Child age 26 or older, who is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, provided the Child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Child must be unmarried, primarily dependent upon you for support, reside with you for more than one-half of the Calendar Year and not eligible for any other type of health coverage (other than Medicaid or Medicare). The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

"Child" includes:

   a. a natural child following birth; or

   b. a legally adopted child; or

   c. a child legally placed in the employee's home for the purpose of adoption by the employee; or

   d. a stepchild; or

   e. a foster child or a child for whom the employee is a Legal Guardian; or

   f. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

Eligibility Date
(See "Persons Covered and Effective Dates" section for enrollment details and effective dates.)

Employee: The first day of the month coinciding with or after you meet the Plan's definition of an Eligible Employee. At no time will coverage begin later than 90 days after you meet the Plan's definition of an Eligible Employee.

Dependent: The same as the employee's Eligibility Date, if you have Eligible Dependents when you first become eligible to participate in the Plan.

Open Enrollment
(See "Persons Covered and Effective Dates" section for enrollment details)

The Open Enrollment period is the month of November. Coverage for a Participant enrolling during Open Enrollment is effective on the first day of January following enrollment.

Schedule of Medical Benefits

This is only a summary of the Plan's benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. You may find the Definitions section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for Utilization Management and Exclusive Provider Organization, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You also may contact Gilsbar, L.L.C., the Benefits Services Manager, or the Plan Administrator for assistance. All maximums are per Participant, unless specifically noted as per family.

For any benefit subject to a Calendar Year and/or Lifetime maximum, Allowable Charges that accumulate towards the benefit limit include any ancillary Allowable Charges associated with that benefit, including but not limited to, office visits, lab tests, X-rays, physician services, etc.

BENEFIT DESCRIPTION	EPO	NON-EPO
OVERALL CALENDAR YEAR MAXIMUM	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Participant	$500	Not covered
Per Family	$1,500	Not covered
MAXIMUM OUT-OF-POCKET EXPENSES PER CALENDAR YEAR		
Per Participant	$2,000	Not covered
NOTE: The following charges do not apply toward the out-of-pocket expense amount and are never paid at 100%: • Deductibles, copayments, and Utilization Management penalties • Prescription drug card copayments and expenses		
UTILIZATION MANAGEMENT PENALTY		
$300 additional deductible applied per occurrence for failure to precertify diagnostic tests over $1,000), home health care and infusion therapy (including chemotherapy), inpatient confinements, psychological and neuropsychological testing, and surgical procedures over $1,000 (including in-office procedures). See the Utilization Management section for details.		
COPAYMENTS AND BENEFIT PERCENTAGES		
Ambulance	80%, no deductible	Not covered
Bariatric Surgery	80% after deductible	Not covered
See the Medical Benefits section for more details about this benefit. See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		

BENEFIT DESCRIPTION	EPO	NON-EPO
Behavioral/Mental Health and Substance Use Disorders – Inpatient (Precertification required) (Includes residential treatment)		
Phoenix or Tucson facilities	100% after deductible	Not covered
Other facilities	80% after deductible	Not covered
Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization)		
Office visits (including psychotherapy in office) (Office visits for Attention Deficit Disorder are only covered to monitor medication)	$25 copay, then 100%, no deductible	Not covered
Services other than in a Physician's office	80% after deductible	Not covered
Chemotherapy & Radiation Therapy (Precertification required)	80% after deductible	Not covered
See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		
Chiropractic Treatment (Eligible charge $40/visit) (30 visits Calendar Year maximum) (Office visit and X-ray charges apply to the maximum)	$25 copay, then 100%, no deductible	Not covered
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) (Precertification required on diagnostic tests over $1,000)	80% after deductible	Not covered
Diagnostic Testing (X-ray, lab) – Inpatient		
Phoenix or Tucson facilities	100% after deductible	Not covered
Other facilities	80% after deductible	Not covered
Benefits are paid according to which facility the services are performed in.		

BENEFIT DESCRIPTION	EPO	NON-EPO
Diagnostic Testing (X-ray, lab) – Outpatient (Services other than in a Physician's office) (Precertification required on diagnostic tests over $1,000)		
X-ray	80% after deductible	Not covered
Lab	100% after deductible	Not covered
Diagnostic Testing (X-ray, lab) – Office (Precertification required on diagnostic tests over $1,000)	$25 copay, then 100%, no deductible	Not covered
Durable Medical Equipment	80% after deductible	Not covered
Emergency Room	$150 copay, then 80% after deductible	
Copay waived if admitted directly to Hospital from Emergency room.		
Emergency Room charges for a condition that is not an Emergency will not be covered.		
Extended Care/Skilled Nursing Facility	80% after deductible	Not covered
Foot Conditions	80% after deductible	Not covered
See the Medical Benefits section for more details about this benefit.		
Hearing Aids ($1,500 Lifetime maximum, including cochlear implants)	80% after deductible	Not covered
Hearing Exam	$25 copay, then 100%, no deductible	Not covered
Home Health Care (60 visits Calendar Year maximum) (Precertification required for Home health care and infusion therapy)	80% after deductible	Not covered
Hospice Care (100 days Calendar Year maximum, including Bereavement Counseling)	80% after deductible	Not covered
Attending Physician must renew the Hospice Care plan every 30 days.		

BENEFIT DESCRIPTION	EPO	NON-EPO
Hospital/Facility Inpatient Expenses (Precertification required) Phoenix or Tucson facilities	100% after deductible	Not covered
Other facilities	80% after deductible	Not covered
Room and Board is limited to the semi-private room rate, or if the Hospital has private rooms only, 100% of the lowest private room rate. Eligible charge for ICU is the ICU charge.		
Hospital/Facility Outpatient Expenses	80% after deductible	Not covered
Infertility/Sterility (Limited to diagnosis only)	80% after deductible	Not covered
Maternity Prenatal care as recommended by the USPSTF	100%, no deductible	Not covered
Other prenatal and postnatal care Initial visit	$25 copay, then 100%, no deductible	Not covered
Subsequent visits	80% after deductible	Not covered
Ultrasound limited to one per pregnancy. Maternity related expenses for dependent Children are covered. See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		
Newborn Care – Routine Inpatient (Circumcisions covered at any time)	80% after deductible	Not covered
See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		
Organ Transplants	80% after deductible	Not covered
See the Medical Benefits section for more details about this benefit. See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		
Orthotics/Prosthetics	80% after deductible	Not covered

BENEFIT DESCRIPTION	EPO	NON-EPO
Physician Services		
Inpatient Visits	80% after deductible	Not covered
Inpatient Surgery	80% after deductible	Not covered
Outpatient Visits	80% after deductible	Not covered
Outpatient Surgery (Physician's fee for services not performed in a Physician's office) (Precertification required on surgery over $1,000)	80% after deductible	Not covered
Office visits (Precertification required on surgery over $1,000)	$25 copay, then 100%, no deductible	Not covered
Copay is per provider and applies only to office visit charge, X-ray & lab services, allergy testing, allergy treatment, injections, minor office surgery and supplies. Copay is waived for allergy injections when not part of an office visit. If more than one Physician is seen in the same office on the same day, only one copay will apply. If another Physician is seen at another office on the same day, a second copay will apply.		
Prescription Drugs (Inpatient)	See **Hospital / Facility Inpatient Expenses**	
Prescription Drugs (Outpatient)	See the **Schedule of Prescription Drug Benefits** subsection	
Preventive Care Routine office visit, physical exam, X-ray & lab, skin cancer screenings, gynecological exam (1 per Calendar Year), pap smear (1 per Calendar Year), mammograms ((limited to 1 for age 35-39, and once annual thereafter), immunizations age 6 and over, colon exam, colonoscopy, and all other services recommended by the USPSTF.	$25 copay, then 100%, no deductible	Not covered
Immunizations up to age 6 and flu shots (including the combination vaccine for influenza and pneumonia) at any age	100%, no deductible	Not covered
Any other routine services not included above ($500 maximum per Participant, per Calendar Year)	$25 copay, then 100%, no deductible	Not covered

BENEFIT DESCRIPTION	EPO	NON-EPO
Rehabilitation Services (Physical, Occupational, Speech, & Cardiac Rehab Therapies)	80% after deductible	Not covered
Cardiac Rehabilitation is limited to Phase 1 and 2 only.		
See the **Hospital/Facility Inpatient Expenses** benefit for inpatient facility services.		
Sterilization Vasectomy (only Physician's charges for in-office procedure are covered; facility charges are not covered) Female sterilization as required by recommended by the USPSTF	80% after deductible See **Preventive Care**	Not covered Not covered
Urgent Care Facility (includes all covered charges billed by facility)	$40 copay, then 100%, no deductible	Not covered
Other Covered Expenses	80% after deductible	Not covered

Schedule of Prescription Drug Benefits
The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefit section for a description of covered expenses and benefit exclusions and limitations.

Prescription Card Options	Copayment
Retail Pharmacy Option (30-day supply)	
All covered Generic Drugs and some lower cost Brand Name Drugs	$10
Preferred Brand Drugs and Preventive Drugs*	$25
Non-Preferred Brand Name Drugs	$50
Specialty Drugs (Available only through the Navitus Specialty Rx Program)	$50
Retail Pharmacy Option (90-day supply)	
All covered Generic Drugs and some lower cost Brand Drugs	$14
Preferred Brand Drugs and Preventive Drugs	$62.50
Non-Preferred Drugs	$125
Mail Order Option (90-day supply)	
All covered Generic Drugs and some lower cost Brand Drugs	$10
Preferred Brand Drugs and Preventive Drugs	$50
Non-Preferred Drugs	$100

*Copayment is waived for flu shots (including the combination vaccine for influenza and pneumonia).

Brand Name means a trade name medication.

Generic drug means a prescription drug that 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.

Non-Preferred Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list.

Preferred Brand Name drug means a trade name prescription medication that is on the Formulary Brand Name drug list of safe, effective therapeutic drugs specifically covered by this Plan.

Preventive Drugs means those recommended by the United States Preventive Services Task Force (USPSTF), including prescribed preventive medications and FDA-approved contraceptives.

Specialty Drugs are available only through the Navitus Specialty Rx Program and include, but are not limited to, self-injectables and biologics, typically used to treat patients with chronic illnesses or complex diseases.

Schedule of Dental Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Dental Benefits section for a description of covered expenses and benefit exclusions and limitations. The Calendar Year deductible for medical benefits does not apply to dental services.

NOTE: Coverage for dental benefits is elected separately from coverage for medical benefits, and a separate employee contribution is required. Contact your Plan Administrator for details.

DEDUCTIBLES

DENTAL DEDUCTIBLE (waived for Type I expenses)	
Per Participant, per Calendar Year	$50
Per Family, per Calendar Year	$150

BENEFIT PERCENTAGES & MAXIMUMS

The Calendar Year maximum is for Type I, II, and III benefits combined. The Lifetime maximum is for Type IV benefits only. The chart below details only dollar maximums. See the Dental Benefits section for a list of visit maximums for each type of benefit.

BENEFIT DESCRIPTION	PERCENTAGE PAYABLE	MAXIMUM BENEFIT	BENEFIT LIMIT FOR LATE ENROLLEES
Type I - Preventive	100%, no deductible	$1,250 Calendar Year maximum for Types I, II, and III combined	No limitation
Type II - Basic Restorative	80% after deductible		
Type III - Major Restorative	50% after deductible		
Type IV - Orthodontics	50% after deductible	$1,500 Lifetime maximum	No benefits for first 24 months

Schedule of Vision Benefits

The following schedule references vision benefits provided by a separate, fully-insured vision policy and are not considered a part of this Plan. Please contact your Plan Administrator for details and a copy of the vision policy. Coverage for vision benefits is elected separately from coverage for medical benefits and dental benefits, and a separate employee contribution will be required. Refer to the vision policy for a description of covered expenses and benefit exclusions and limitations; if there are any discrepancies between the benefits referenced below and the vision policy, the vision policy will govern.

BENEFIT DESCRIPTION	COPAYMENT	MAXIMUM BENEFIT	LIMITATIONS
Vision Examinations	$10	No maximum	Limited to 1 exam per Calendar Year
Materials			
Frames	$35	$130 maximum	Frames limited to 1 pair every 24 months
Lenses	$35	No maximum	Lenses limited to 1 pair every 12 months
Contact Lenses	No copayment	$130 maximum	Contact lenses must be in lieu of frames/lenses

No benefits are payable in excess of a maximum benefit. Charges in excess of the maximum benefit are the responsibility of the Participant.

DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical or dental treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee's occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time may be used by the Employer to determine if a Variable Hour Employee averaged at least 30 hours per week during the Measurement Period and, if so, to make an offer of coverage. Any applicable Administrative Period will not exceed 90 days.

Allowable Charge: See the 'Reasonable and Customary and Allowable Charge' definition.

Benefit Services Manager: Gilsbar, L.L.C., the entity that performs certain contracted nondiscretionary administrative services (including, but not limited to, claims processing) for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Birthing Center: A place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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

Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one month during which the Covered Employee or Covered Dependent was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

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

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)

Eligible Employee: (See Highlights section.)

Emergency: A severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable layperson to believe that failure to obtain immediate medical attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions are:

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are having a medical emergency, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.

Employer: Northern Arizona Council of Governments, including any affiliate or subsidiary thereof.

ERISA: The Employee Retirement Income Security Act of 1974, as from time to time amended.

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

Exclusive Provider Organization or EPO: A network of providers offering discounted fees for services and supplies to Participants. The network will be identified on the Participant's Plan identification card.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply which:

1. is not recognized by the state or national medical communities;

2. does not have final approval from the appropriate government regulatory bodies of the United States;

3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

4. is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;

2. A school or similar institution;

3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or

4. Engaged in Custodial Care.

Full-time Employee or Full-Time Employment: With respect to a calendar month, an Employee who is employed an average of at least 30 hours of service per week with the Employer, for the purpose of determining who is a Full-time Employee under the Patient Protection and Affordable Care Act.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: An agency that:

1. Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his home;

2. Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;

3. Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;

4. Provides for full-time supervision of such services by a Physician or by a registered Nurse; and

5. Maintains a complete medical record of each patient.

Home Health Care Expenses: The Allowable Charge made by a health care agency for the following necessary services or supplies furnished to the Covered Employee or Covered Dependent in such individual's home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

1. Part-time or intermittent nursing care by or under the supervision of a registered Nurse;

2. Part-time or intermittent home health care aide services that consist primarily of caring for the patient;

3. Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or

4. Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Covered Employee or Covered Dependent been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;

2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;

3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A bodily or Mental/Emotional Disorder of any kind of any Participant. Illness includes pregnancy for the purpose of benefit determination. Illness also includes Injury where appropriate to the context.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital as a registered bed patient and who is charged at least one day's room and board by the Hospital.

Late Enrollee: A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan; or

2. during a Special Enrollment Period.

Legal Guardian: 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 an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant's covered expenses, even if other provisions of the Plan appear to entitle the Participant to more. “Lifetime” shall mean while covered under this Plan or any other plan maintained by the Employer.

Marriage or Married: A union that is legally recognized as a marriage under the state law where such marriage was performed.

Measurement Period: A period of time selected by the Employer during which a Variable Hour Employee's hours of service are tracked to determine if they average at least 30 hours during this period. The beginning dates and the lengths of each Measurement Period are set by the Plan Sponsor and will be applied uniformly to each category of employees.

- Initial Measurement Period: For a newly-hired Variable Hour Employee, this Measurement Period may start at any time from the date of hire to the first day of the month after the employee begins working and end no later than after the first 12 months of service.

- Standard Measurement Period: For Ongoing Employees, this Measurement Period will start on the same day each year and will last no longer than 12 months.

Medically Necessary or Medical Necessity: Describes medical or dental treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;

2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;

3. Is not primarily Custodial Care; and

4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

Medicare: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Mental/Emotional Disorder: Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental/Emotional Disorders include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Morbid Obesity: means the Participant meets 1 or more of the following:

a. Has a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight for a person of the same height, age and mobility as the Participant;

b. The Participant has a Body Mass Index (BMI) of 40 or more; or

c. The Participant has a Body Mass Index (BMI) of 35 or more and the plan participant also, at the same time, suffers from two or more co-morbid medical conditions such as life threatening pulmonary problems, severe diabetes, or severe joint disease surgically treatable except for the obesity, but such conditions may be improved by the performance of the bariatric surgery.

New Employee: An Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

Nurse: A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his family.

Occupational Therapy: The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Ongoing Employee: An Employee who has been employed by the Employer for at least one complete Standard Measurement Period.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.
Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;

2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;

3. Provides at least two operating rooms and one post anesthesia recovery room;

4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;

5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;

6. Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Partial Hospitalization: A structured, Hospital-based program. Patients receive intense treatment usually between the hours of 8 a.m. and 5 p.m., Monday through Friday, and are capable of remaining in their home environment in the evenings. Individual, group or family therapy is provided a minimum of four hours a day, three times a week.

Participant: Any Eligible Employee or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, covered person, and member have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and

2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: Northern Arizona Council of Governments.

Plan Document: This Plan Document and Summary Plan Description.

Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Reasonable and Customary and Allowable Charge:

Reasonable and Customary: For the purposes of the plan generally, a charge is considered Reasonable and Customary:

1. If the charge is made for medical or dental services or supplies essential to the care of the Participant; and

2. If the charge is in the amount normally charged by the provider for similar services and supplies; and

3. If the charge does not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received.

Whether a charge is Reasonable and Customary may be established by the Plan Administrator by use of any customary or accepted method.

Allowable Charge: The following are Allowable Charges under this plan and are agreed to be Reasonable and Customary:

1. A contracted rate of an Exclusive Provider Organization servicing the Plan with the agreement of the Plan Administrator is an Allowable Charge.

2. A charge billed by a Non-EPO provider is determined to be an Allowable Charge under the following rules applied in the order of priority as they are listed:

    a. If the Plan Administrator determines that the Allowable Charge is a lower amount than is otherwise applicable under the following rules, then that lower amount is the Allowable Charge;

    b. If the billed charge is discounted according to an agreement negotiated specifically for the patient by the Plan Administrator directly with the provider, the Allowable Charge is the discounted charge;

    c. If the billed charge is for dialysis, the Allowable Charge is the lesser of the billed charge or one-hundred thirty percent (130%) of the Medicare allowable charge;

    d. If the billed charge is for chemotherapy drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug;

    e. If the billed charge is for specialty drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug minus fifteen percent (15%);

    f. If the billed charge is for specialty drugs dispensed by a facility on an Inpatient or Outpatient basis, the Allowable Charge is the lesser of the billed charge or 150% of the average wholesale price;

g. If the billed charge is for an implant (including but not limited to knee and hip replacements, pins, rods, cochlear implants, ocular implants), the Allowable Charge is the lesser of the billed charge or one and one-half (1 ½) times the invoice amount of the supplies;

h. If the billed charge is discounted according to an agreement with a repricing service that covers the Plan, the Allowable Charge is the discounted amount;

i. If the medical or dental service or supply appears on the Reasonable and Customary Table utilized by the Plan Administrator, then the Allowable Charge is the lesser of the billed charge or the amount as listed on the Table;

j. If the billed charge is a facility charge that does not appear on the Reasonable and Customary Table utilized by the Plan Administrator, then the Allowable Charge is the lesser of the billed charge or 200% of the Medicare allowable charge; and

k. If none of the foregoing applies, the Allowable Charge is the billed charge.

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Residential Treatment Center: A facility that provides treatment 24 hours a day and can usually serve more than twelve people at a time. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent mental illness that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time or (2) substance abuse in which the patient is at a high risk for relapse.

Routine Dental Exam: Exam by dentist not required because of Illness or Injury.

Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: An individual who is legally married to a Covered Employee.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's eligibility status is fixed.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description: This Plan Document and Summary Plan Description.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems 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 is not limited to, orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient's care and treatment.

Variable Hour Employee: An Employee is considered a Variable Hour Employee if, based on the facts and circumstances at the Employee's start date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 hours of service per week during the initial measurement period because the Employee's hours are variable or otherwise uncertain.

PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage

If you are an Eligible Employee as defined by the Plan in the Highlights, **you will automatically be enrolled in the Plan unless you waive coverage within 31 days of becoming eligible**. If you waive medical coverage, you must certify in writing that you have medical coverage elsewhere. If you are a Late Enrollee, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, or your whole family. Your **Eligible Dependents will NOT automatically be enrolled; you must elect coverage for your Eligible Dependents within 31 days of becoming eligible or they will be considered Late Enrollees**. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage

Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you waive coverage within 31 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 31 days of a Special Enrollment event described later in this section.
However, if you were covered under the plan offered by the Plan Sponsor as of the effective date of this plan document, your Eligibility Date is the effective date of this plan document.

Your coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on your Eligibility Date, unless you waive coverage; or

2. If you are a Late Enrollee, at 12:01 A.M. on the first day of January following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling during a Special Enrollment period, see the subsection below entitled “Special Enrollment Periods.”

If, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Effective Date of Dependent Coverage

Your dependents may be covered under the Plan only if you are a Covered Employee and if the dependents meet the Plan's requirements for Eligible Dependents. If you have Eligible Dependents

when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is the same as your Eligibility Date. Any dependent not enrolled within 31 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 31 days of a Special Enrollment event described later in this section.

Dependent coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage within 31 days of becoming an Eligible Employee; or

2. If you or your dependent is a Late Enrollee, at 12:01 A.M. on the first day of January following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling your dependent during a Special Enrollment period, see the subsection below entitled "Special Enrollment Periods."

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Contributory coverage for a newborn child is effective on the date of birth only if application is made within 31 days after this date. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 31 days after this date. These are exceptions to provision (1) above.

Special Enrollment Periods

The employee must make a request for Special Enrollment to the Plan Administrator within 31 days of marriage, birth, adoption or the loss of other coverage (other than Medicaid or a State Children's Health Insurance Program). The request must be made on an enrollment form to the Plan Administrator.

Coverage is effective as follows:

1. For marriage, the first day of the month following enrollment.

2. For loss of other coverage, the first day of the month following enrollment.

3. For birth or adoption, the date of birth or adoption, or the date the child is placed in the home for adoption.

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children's Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for Special Enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

If an employee or a dependent does not enroll within 31 days of marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee and may enroll only during the Open Enrollment Period.

Open Enrollment Period

The Open Enrollment Period and the corresponding coverage effective date are shown in the Highlights section. During the Open Enrollment Period only, the Plan allows an Eligible Employee (and/or his Eligible Dependents) who is not currently enrolled and who has completed any waiting period (i.e., a Late Enrollee) now to elect coverage.

During the Open Enrollment period only, Eligible Employees who are currently enrolled may also elect to change their plan selection, add or drop dependents, or drop coverage altogether.

NOTE: Coverage for any Eligible Employees and Eligible Dependents who are currently enrolled will continue in force from year to year without making a new election during the Open Enrollment Period, unless otherwise notified.

Change in Family Status

Once you are in the Plan, you must notify the Plan Administrator within 31 days of <u>any</u> family status change, such as a newborn baby, or when your first family member becomes eligible, or when you no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.

Change in Coverage Status

If your coverage status changes from dependent to employee or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Employees

When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse will be treated as a dependent for billing purposes and in

calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Election of Coverage Regarding Medicare

Medicare regulations applicable to employers with twenty or more employees require that any active Participant who has reached age 65 and is eligible for Medicare must choose one of the following coverage options:

1. Primary coverage under this Plan (Plan benefits will be paid without regard to Medicare), or

2. Sole coverage under Medicare (coverage under this Plan will terminate).

When eligible, Plan Participants must enroll in Medicare coverage in a timely manner in order to assure maximum coverage.

Court-ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a "medical child support order" ("MCSO") or "national medical support notice" ("NMSN") that is a "qualified medical child support order" ("QMCSO") if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

"Alternate recipient" shall mean any child of a Covered Employee who is recognized under a MCSO as having a right to enrollment under this Plan as the Covered Employee's Eligible Dependent. "MCSO" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee's child or directs the Covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

"NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s)); and

4. Identity of an underlying child support order.

"QMCSO" is an MCSO that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "NMSN";

    a. Identifies either the specific type of coverage or all available group health coverage. If the employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the employer and the Plan Administrator will assume that all are designated; or

    b. Informs the Plan Administrator that, if a group health plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    a. Whether the child is covered under the Plan; and

    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

"GINA"

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

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

1. Such individual's genetic tests;

2. The genetic tests of family members of such individual; and

3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

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

EXCLUSIVE PROVIDER ORGANIZATION

The Exclusive Provider Organization ("EPO") is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you may access a list of providers that belong to the EPO network through the website located at www.myGilsbar.com. It is the Participant's choice as to which provider to use.

When medical care is needed, be sure the provider is still under contract with the EPO shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the EPO before services are rendered.

Refer to the section entitled "DEDUCTIBLES, COPAYMENTS, AND OUT OF POCKET EXPENSES" for services that require a copayment.

Eligible expenses for services rendered in an EPO Hospital by a Non-EPO provider, including, but not limited to, an anesthesiologist, radiologist or pathologist, will be payable at the same benefit percentage level that an EPO provider would be paid for such services if you did not have the option of choosing an EPO provider. All other charges by Non-EPO providers will be excluded, even if you are referred to the Non-EPO provider by an EPO provider, unless specifically covered below.

When you receive care from an EPO provider, the benefit percentage payable for your covered expenses will be the percentage shown in the Highlights. When you receive care from a Non-EPO provider, the expenses will be excluded; however, the Non-EPO expenses may be covered and payable at the EPO level under the following circumstances (and as described above for charges such as an anesthesiologist, radiologist, or pathologist):

1. If you have an Emergency requiring immediate care;

2. If you believe there are no EPO specialists who have the specific knowledge and training necessary to meet your medical needs, you request prior approval to use a Non-EPO provider, and your request is approved; or

3. If you have an organ transplant and the use of a Non-EPO facility is approved by the Plan Administrator.

A current list of EPO network providers is available, without charge, from the networks listed below or through the website located at www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer.

- BlueCross® BlueShield® of Arizona – for all Participants
- HMN Network – for Participants who work at the Page or Fredonia locations.

BlueCross® BlueShield® of Arizona, an independent licensee of the Blue Cross and Blue Shield Association, provides network access only and provides no administrative or claims payment services and does not assume any financial risk or obligation with respect to claims. No network access is available from Blue Cross Blue Shield plans outside of Arizona.

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

DEDUCTIBLES, COPAYMENTS, AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Participant pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan. The Plan Sponsor determines these amounts.

Calendar Year Deductible

The Calendar Year deductible is the amount of covered expenses Incurred by an individual during the Calendar Year for which no benefits will be paid. After you or a Covered Dependent has satisfied the Calendar Year deductible, the Plan pays a certain percentage of the covered expenses for that individual that are Incurred during the rest of the Calendar Year. Deductible accumulation period is January 1 through December 31. Copayments do not accrue toward the deductible.

Family Calendar Year Deductible

If the dollar amount of the family Calendar Year deductible, shown in the Highlights, is satisfied by the combined covered expenses applied to the individual deductibles of several Participants in a family, no additional Calendar Year deductible amount is required to be satisfied by the Participants of that family for covered expenses Incurred during the remainder of the Calendar Year. Once a Participant has satisfied the individual deductible, no additional covered expenses for that person will be counted toward the family deductible.

Deductible for Services Requiring Precertification (Utilization Management)

If you do not precertify your inpatient confinement with the Utilization Management organization, covered expenses billed by the facility and Incurred during that confinement will be subject to the per-confinement deductible shown in the Highlights in addition to the Calendar Year deductible and any other applicable deductibles. Other services or supplies, if any, that require precertification will be subject to the same Utilization Management deductible for failure to precertify. See the Utilization Management section for details on how to precertify a scheduled inpatient confinement and what to do when you are admitted to the Hospital unexpectedly.

Copayments

The copayment amount and the applicable benefit percentage for Physician office visits are shown in the Highlights. A Participant is required to pay only the listed copay amount for same-day office visit services by a EPO Physician and, if applicable, the copay amount for same-day services by a EPO laboratory. The copay applies to the services outlined in the Schedule of Medical Benefits.

Any EPO charge (1) for a service rendered on a different day, (2) for a service rendered outside the Physician's office (except as set forth above), or (3) billed as a separate facility fee is specifically excluded from the copay benefit associated with the original office visit. Such charges will be considered for payment by other applicable benefit provisions of the Plan. After the copay, the Plan will apply the applicable benefit percentage to the remaining covered expenses up to the maximum office visit limit, if any, and then the appropriate deductibles, benefit percentages and other Plan limits apply.

Out-of-Pocket Expense

Out-of-pocket expense is the amount of covered expenses you must pay after the satisfaction of the Calendar Year deductible before certain benefits begin to be paid at one hundred percent (100%).

If during the Calendar Year your out-of-pocket covered expenses satisfy the out-of-pocket expense amount, the rate of payment for certain covered charges will be increased to a full one hundred percent (100%). The one hundred percent (100%) will continue for covered expenses Incurred during the remainder of that Calendar Year. You must satisfy your deductible plus your out-of-pocket amount before these benefits will be paid at one hundred percent (100%).

NOTE: See Highlights for a list of charges that do not apply to the out-of-pocket expense amount.

MEDICAL BENEFITS

Covered Medical Expenses

Covered expenses (sometimes identified as covered charges, eligible charges, eligible expenses or similar terms) include only the Allowable Charges that:

2. Are Medically Necessary for the care and treatment of Illness or Injury of a Participant; and

3. Are recommended by an attending Physician; and

4. Do not exceed the Reasonable and Customary charge; and

5. Are not excluded by other provisions applicable to this coverage.

The following expenses are covered by the Plan provided they meet the requirements for covered medical expenses described above and are not excluded elsewhere in the Plan. Reimbursement is based upon the Lifetime and Calendar Year limits, benefit percentages and other limitations previously described in the Highlights section.

1. **Allergy services**: Allergy testing, serum and injections will be payable as shown in the Medical Schedule of Benefits. Injections of food allergy antigens and the like are not eligible expenses. The allowance for antigens will be based on a 3-month supply and a per vial cost.

2. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency care. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary for life-threatening illness or injury.

3. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.

4. Office visits to monitor medication for **attention deficit**/hyperactivity disorder.

5. **Bariatric surgery** if the plan participant meets all of the following criteria and the procedure is performed by EPO providers (surgeons, assistant surgeons, anesthesiologists, etc.) at an EPO facility known to have an effective program for doing such a surgery and a follow-up program:

    a. The Participant has been covered under the this Plan for a minimum of 24 months immediately preceding the date of the procedure;

b. The Participant is at least 18 years of age, is physically mature, is not older than 65 years of age;

c. 2 separate physicians confirm in writing that the Participant satisfies all of the following:

   i. meets, and has met for 2 or more years prior to the procedure, the definition of Morbid Obesity;

   ii. is an acceptable surgical interventional risk (i.e. he or she must otherwise be a good surgical candidate); and

   iii. does not have a specifically correctable cause of obesity, such as a glandular or endocrine problem.

d. The Participant provides evidence of physician documented compliance with a structured, medically guided weight reduction program for at least 6 months prior to the proposed surgery and the Participant has failed to maintain weight loss;

e. a licensed psychologist or psychiatrist, a dietitian, an exercise physiologist and a surgeon have confirmed in writing that the Participant has met with them and the Participant is both physically and mentally prepared to undergo the proposed bariatric surgery and a structured post-operative exercise, diet and related follow-up program; and

f. the Participant provides written documentation from a licensed psychologist or psychiatrist confirming the absence of a significant psychopathology that may limit the Participant's understanding of the procedure, ability to comply with medical/surgical recommendations and post-surgery lifestyle changes necessary for the procedure to be successful.

NOTE: Benefits will not be provided for subsequent (repeat or revision) procedures to correct further injury or illness resulting from the Participant's non-compliance with prescribed medical treatment follow-up post-surgery.

Expenses which are medically necessary, in connection with services or supplies and surgical procedures performed in connection with Morbid Obesity (including complications), will receive benefits as described in the Schedule of Medical Benefits.

6. **Blood** and blood derivatives that are not donated or replaced, except that autologous blood donations will be covered only if blood is actually used during a scheduled surgery.

7. **Cardiac rehabilitation** services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated

within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to Occupational Therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

8. **Chiropractic** treatment.

9. **Contraceptives**: Contraceptive procedures and medications including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the prescription drug card program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

10. Rental of **durable medical equipment** when such equipment is deemed Medically Necessary, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Plan Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. Only one manual wheelchair, motorized wheelchair, or motorized scooter will be covered, unless Medically Necessary due to growth of the Participant or if changes to the Participant's medical condition require a different product, as determined by the Plan Administrator.

11. Room, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care.

12. **Foot Care**: Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; and (d) any Medically Necessary surgical procedure required for a foot condition. Charges for Medically Necessary orthopedic shoes and other related supportive appliances, including their replacement once in each 12-month period, or, if under 19 years of age, once in each 6-month period if necessitated by the child's growth. Orthotics will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory.

13. **Hearing aids** and cochlear implants, up to the maximum shown in the "Schedule of Medical Benefits." Also, the examinations to determine the need for, or the proper adjustments of**,** hearing aids are covered.

14. **Hemodialysis/Peritoneal Dialysis**: Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Participant's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Participant's home as shown under the Durable Medical Equipment benefit.

15. **Home health** care, if prescribed by a Physician as a plan of treatment. The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

16. **Hospice** care. Covered charges are as follows:

    a. Inpatient Hospice care;

    b. Services of a Physician;

    c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds;

    d. Emotional support services and physical/chemical therapies; and

    e. Bereavement counseling sessions for covered family members following the death of a Terminally Ill Participant.

17. **Hospital** room and board, at the semi-private Hospital room and board rate. If confinement is in a Hospital providing private rooms only, the covered expense shall be no greater than the rate listed in the Schedule of Benefits. If Medical Necessity requires an intensive care unit or intermediate care unit, the Plan will cover the room and board up to the maximum listed in the Schedule of Benefits.

18. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician's and other professional services.

19. Diagnosis of **infertility** or sterility.

20. Medical **laboratory** charges in connection with treatment of an Illness or Injury.

21. **Lenses**: initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages are covered.

22. **Licensed Birthing Center**: Charges by a freestanding or Hospital based, public or private institution, other than private offices or clinics of Physicians, which is licensed by the State as a Birthing Center or is associated with a licensed Hospital and meets the official requirements of the State Department of Health.

23. Treatment of **Mental/Emotional** Disorders.

24. Routine Hospital and Physician care for a **newborn child** prior to discharge from the Hospital. Such care may not be less than 48 hours following a normal delivery or 96 hours following a cesarean section. Refer to "Pregnancy" later in this section for details of the Newborns' and Mothers' Health Protection Act of 1996. The maximum benefit is also 48 hours and 96 hours, respectively. Charges for routine newborn care will be covered under the mother's claim if she is covered under the Plan. For a newborn child to receive this benefit, the child must be enrolled in the Plan within 31 days after birth. Charges for circumcision of a Child born while covered under the Plan will be covered prior to and after discharge from the Hospital.

25. **Occupational Therapy** performed by a licensed occupational therapist and ordered by a Physician. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury. It must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.

26. Covered medical expenses Incurred for care and treatment due to an **organ transplant** are subject to the following:

    a. The recipient must be a Participant in the Plan;

    b. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant approved by the FDA that is not Experimental or Investigational. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan;

    c. Charges for obtaining donor organs are covered under the Plan when the recipient is a Participant. Donor charges include those for:

        i. removing the organ from the donor; and

        ii. transportation of the organ to the place where the transplant is to be performed.

d. Except as provided under (c) above, organ procurement does not include donor-related expenses while the Participant is awaiting the transplant, unless the donor is covered under this Plan.

Prior to undergoing the procedures, the Participant who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Participant's condition.

27. The initial purchase, fitting and repair of an **orthotic appliance** (including corrective or orthopedic shoes, arch supports or other similar, corrective foot devices or appliances, subject to the replacement limitations described under the "foot care" benefit in this section) such as a brace, splint or other appliance required for support of a malfunctioning or deformed limb as a result of Injury, Illness or a disabling congenital condition. Orthotics will only be covered when ordered by a M.D. or D.P.M. and dispensed by a certified orthotics laboratory. The Plan will cover subsequent repair, modification or replacement of the appliance only if the attending Physician certifies in writing that it is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing orthosis is unusable and cannot be repaired or modified to achieve proper fit and function.

28. **Outpatient Surgery** charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

29. **Physician's** fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan.

30. **Physical therapy** by a licensed physical therapist or qualified Physician. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury.

31. **Preadmission testing** ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an

Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.

32. **Pregnancy** expenses. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

33. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician's written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).

34. **Preventive** care services, as listed in the Schedule of Medical Benefits, and including breast pump supplies and rental of breast pumps for female Participants during breastfeeding. Breast pumps may be purchased if, in the judgment of the Plan Administrator, purchase would be less expensive than rental or a breast pump is not available for rental; if purchased, the Plan will cover replacement only once per Calendar Year.

35. Replacement of a natural eye or limb with an artificial one (**prosthesis**), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

36. **Radiological** tests (X-rays), radium treatments, and treatments with other radioactive substances.

37. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the

Participant. Up to 6 prosthesis bras will be covered in a Calendar Year. Reimbursement will be made according to the "Schedule of Medical Benefits" section by type of service.

38. **Rehabilitation Hospital** charges, provided all the following conditions are met:

    a. The patient has a physical disability, and his medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

    b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the patient through the Hospital's rehabilitation program; and

    c. The patient requires close medical care by a Physician and 24-hour-a-day nursing supervision.

    The Utilization Management organization must be notified of the intended stay.

39. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.

40. **Sleep disorder treatment** for sleep apnea, only when Medically Necessary.

41. **Speech therapy** by a qualified speech therapist. The therapy must be to restore or rehabilitate speech loss due to an Illness or Injury or due to surgery for an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

42. Elective surgery for **sterilization**, including tubal ligation, female sterilization by any other FDA-approved method, and vasectomy (see the subsection "Schedule of Medical Benefits" for limitations on vasectomy).

43. Treatment of **Substance Abuse**.

44. Medical **supplies** that are Medically Necessary for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches. Covered supplies also include anti-embolism garments (e.g., Jobst) up to 3 per Calendar Year.

45. **Surgeon's** fees for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Reasonable and Customary fees in his area. Charges for **multiple surgical procedures** are subject to the following provisions:

    a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

    b. If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and

    c. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the primary surgeon's allowance.

UTILIZATION MANAGEMENT

Utilization Management Company Phone Number
Please refer to the Employee ID card for the Cost Management Services phone number.

Typically, the EPO provider will call to receive certification of cost management services, but ultimately it is the Participant's responsibility to receive certification if the EPO provider does not. The patient or family member can call the phone number on the Employee ID card to receive certification of certain cost management services. This call must be made in advance of services being rendered, or within 48 hours or on the first business day after an emergency.

Failure to precertify required medical services will result in the application of the Utilization Management Penalty, if any, shown in the Schedule of Medical Benefits.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the maximum out-of-pocket limit.

Utilization Management
Utilization Management ("UM") is a program designed to help ensure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

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

Diagnostic tests over $1,000
Home health care and infusion therapy (including chemotherapy)
Inpatient confinements
Surgical procedures over $1,000 (including in-office procedures)

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

(c) Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and

(d) Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.

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.
If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The UM organization's staff cannot and does not verify benefits or eligibility. The UM organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UM program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

Here's how the program works.

Precertification
Before a Participant enters a medical care facility on a non-emergency basis, the Utilization Management 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 the Participant. Contact the Utilization Management administrator at the telephone number on your 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, social security 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, and
- 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 utilization management administrator **within 48 hours** or on the first business day after the admission.

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

The Utilization Management administrator will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Summary Plan Description.

Under the Newborns' and Mothers' Health Protection Act of 1996, 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 following a vaginal delivery, or 96 hours following a cesarean section. Notification is still encouraged at the time of admission, and is **required** for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the UM administrator of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Highlights to the Hospital expenses for the excess days not certified.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management administrator will monitor the Participant's medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities and Participant 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 Participant 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.

Case Management

Case Management is a program whereby a Case Manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The 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, or
- assisting in obtaining any necessary equipment and services.

Case Management occurs when it 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 may consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Participant. The objective of this service is to direct the patient toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, patient and, in some circumstances, the patient's family must all agree to the alternate treatment 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.

Retrospective Utilization Management

When Hospital precertification or continued stay review/discharge planning has not been secured, the UM organization may elect to use retrospective Utilization Management. Retrospective utilization management is the process in which the UM organization evaluates Inpatient, acute care hospitalizations which were not reviewed during the confinement. Using the established medical criteria for Hospital precertification and concurrent review/discharge planning, the UM organization will determine retrospectively the Medical Necessity and appropriateness of Inpatient hospitalization and treatment plan.

PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Card

As a Participant in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the prescription drug card program. If you present this card to a participating retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through the mail-order program, you will be charged as shown in the Highlights. The per Participant, per Calendar Year deductible applicable to medical expenses does not apply to these prescription drug expenses.

A current list of participating pharmacies is available, without charge, through the website located at www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a participating pharmacy, you must pay the full price of the prescription drug and submit a claim form to the prescription drug card company for reimbursement. These expenses are reimbursable only by the prescription drug card company. These claim forms may be obtained from your Human Resources Department. Any claim submitted to Gilsbar, L.L.C. for these expenses will be returned to you with the proper form for reimbursement by the prescription drug card company.

Outpatient prescription drugs purchased from a non-participating pharmacy are not covered under the Plan.

Covered Prescription Drug Card Expenses

Covered prescription drug card expenses are the Reasonable and Customary charges for prescription drugs purchased from a pharmacy participating in the prescription drug card system. Such drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician and do not exceed the Allowable Charge. They are limited to the following:

1. Prescription drugs, including, but not limited to, pre-natal vitamins and vitamins with fluoride;

2. Compounded medications of which at least one ingredient is a prescription drug in a therapeutic amount;

3. Injectable insulin, including insulin syringes and needles, and diabetic supplies furnished on written prescription of a Physician.

Covered expenses may not exceed a 90-day supply when you purchase prescription drugs from a retail participating pharmacy or through the mail-order program. The amount may not be more than the amount normally prescribed by your Physician.

An expense will be considered to be "incurred", for purposes of this benefit, at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations
Charges for the following are excluded unless specifically covered by the Plan or as recommended by the United States Preventive Services Task Force (USPSTF) for preventive care:

1. **Administration**: Any charge for the administration or injection of any drug or medication.

2. **Anorexiants** or any drug or medication used as an appetite suppressant.

3. **Blood** or blood plasma.

4. **Consumed on site**: Any drug or medication which is consumed or administered at the place where it is dispensed.

5. **Contraceptives** or contraceptive devices of any kind, except FDA-approved contraceptives as recommended by the United States Preventive Services Task Force (USPSTF).

6. **Cosmetic purposes**: Drugs used for cosmetic purposes, such as hair growth stimulants or Retin-A for a Participant over age 25.

7. **Devices** of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

8. **Diagnostic** agents.

9. **Experimental/investigational**: Drugs labeled: "Caution–limited by federal law to investigational use," or experimental drugs even though a charge is made to the Participant.

10. **FDA**: Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.

11. **Immunization** agents or biological sera.

12. **Impotence**: Drugs for erectile dysfunction or organic impotence.

13. **Infertility**: Any drug or medication related to or used in the treatment of infertility.

14. **Injectables** & supplies: A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin, as specifically covered under the Specialty Drug benefit, or otherwise herein.

15. **Inpatient medication**: Any drug or medication which is to be taken by or administered to the Participant, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

16. **Medical exclusions**: Any drug or medication otherwise excluded by the medical plan.

17. **No charge**: Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.

18. **No prescription**: Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

19. **Proton pump inhibitors**.

20. **Refills**: Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

21. **Smoking** deterrents or smoking cessation medications or supplies except as recommended by the United States Preventive Services Task Force (USPSTF).

22. **Vitamins**, except pre-natal vitamins and vitamins with fluoride that require a prescription.

DENTAL BENEFITS

If you incur expenses for the covered dental services described below, the Plan will deduct the dental deductible from the amount of the total covered dental expenses (where applicable) and pay a percentage of the remainder, until the maximum benefit is reached for that service. The deductible, Calendar Year and Lifetime maximums, and benefit percentages for dental benefits are listed in the Schedule of Dental Benefits section of the Highlights. The family deductible amount, as shown in the Schedule of Dental Benefits section of the Highlights, is the maximum amount which may be Incurred by the covered family members during a Calendar Year; however, each Participant in a family is not required to meet more than the per Participant deductible amount.

If you apply for dental coverage more than 31 days after the date you first became eligible (i.e. you are a Late Enrollee), your dental benefits for Type IV - Orthodontic Services will be limited as shown in the Schedule of Dental Benefits.

Covered Dental Expenses
Covered expenses include the Reasonable and Customary charges for the services described on the lists of covered services below, provided these expenses are Allowable Charges and are:

1. For services that are essential for the necessary care of the teeth and performed by or under the direction of a licensed Dentist; and

2. Incurred by you or a dependent while covered by the dental provisions of this Plan.

An expense is incurred, for purposes of this section, on the date a service is performed or a supply is furnished, with the following exceptions, for which the expense will be deemed to be incurred as described:

1. For an appliance or modification of an appliance, on the date the master impression is made;

2. For a crown, a bridge, or an inlay or onlay restoration, on the date the tooth is prepared; and

3. For root canal therapy, on the date the pulp chamber of the tooth is opened.

If a particular service is listed under more than one type, the expenses for that service will be covered only under the listing for which you receive the greatest benefit.

Because many dental problems can be resolved in more than one way, the Plan Administrator reserves the right to determine the dental procedure codes as it deems appropriate that will represent the lowest-cost treatment which adequately restores the mouth to normal form and function. The codes used are based on nationally established standards of the dental profession.

Type I -- Preventive or Diagnostic Services
The following are covered expenses:

1. Bitewing X-ray (limited to 1 every Calendar Year)

2. Fluoride treatment (only for dependents under age 19)

3. Initial/periodic exam (limited to 2 every Calendar Year)

4. Palliative treatment (for non-routine, Emergency visits)

5. Panoramic or Full-mouth X-ray (limited to 1 every 36 months)

6. Prophylaxis (limited to 2 every Calendar Year)

7. Sealants (only for dependents under age 19, and only on unrestored, permanent bicuspids and molars)

Type II -- Basic Services
The following are covered expenses:

1. Endodontics (root canals)

2. Extractions (excluding extractions done for orthodontic purposes)

3. Fillings (including amalgam and resin-based composites) and pin retention for fillings. Gold foil restorations are not covered.

4. Intravenous sedation or general anesthesia (covered only in connection with a surgical procedure)

5. Nitrous oxide.

6. Non-routine visits (consultation or observation)

7. Oral surgery (including all eligible charges for surgical removal of impacted wisdom teeth)

8. Surgical and non-surgical periodontic treatment (per quadrant, limited to once every 24 months). Crown lengthening or single tooth gingivectomy is allowed once in conjunction with crown preparation. Periodontal prophylaxis is limited to once every 6 months, not to exceed

2 per Calendar Year. Occlusal adjustments are allowed only in connection with periodontal surgery, and occlusal guards are not covered.

Type III -- Major Restorative Services
The following are covered expenses:

1. Bridge (at least one tooth must have been extracted while covered under this Plan for the bridge to be covered; extraction of a third molar does not qualify). Bridge must be placed within 12 months after the extraction.

2. Bridge replacements, if bridge is unserviceable (limited to 1 every 5 years), and Participant must be covered under the Plan for a minimum of 12 months.

3. Crowns

4. Crown replacements, if crown is unserviceable (limited to 1 every 5 years)

5. Dental implants (only payable up to the benefit allowed for a bridge or partial denture (whichever is less).

6. Denture, full or partial (at least one tooth must have been extracted while covered under this Plan for the bridge to be covered; extraction of a third molar does not qualify). Denture must be placed within 12 months after the extraction.

7. Denture replacements, if denture is unserviceable (limited to 1 every 5 years), and Participant must be covered under the Plan for a minimum of 12 months. Replacements more than 1 every 5 years are only covered if:

    a. such replacement is necessary due to the initial placement of an opposing full denture or extraction of natural teeth;

    b. the denture is a stayplate or similar temporary partial denture, and is being replaced by a permanent denture; or

    c. the denture, while in the oral cavity, has been damaged beyond repair as a result of an Injury that occurs while the individual is covered under the Plan.

8. Inlay/Onlay, and recementing of inlay/onlay

9. Pontics

10. Pontic replacements, if pontic is unserviceable (limited to 1 every 5 years)

11. Post & Core, including pin retention (combine with charge for crown if done in connection with a crown)

12. Reline and rebase denture (only within six months following initial installation)

13. Space maintainers for premature loss of posterior primary teeth (only for dependents under age 14). Anterior space maintainers are not covered.

Type IV -- Orthodontic Services

The following are covered expenses for Participants of any age:

Charges incurred for the detection, active treatment and appliance for the correction of abnormalities of the teeth and malocclusion. Active course of treatment shall mean any services for diagnostic casts, x-rays, records, tooth extraction or the placement of active orthodontic appliances. The active course of orthodontic treatment is the period which begins when the first orthodontic service is performed and ends when the last active appliance is removed. Cephalometric film x-rays are limited to 1 every 3 Calendar Years. Payments for active orthodontic treatment will be processed on a monthly basis prorated over the total period of the orthodontic treatment plan. Expenses for orthodontia services furnished to Covered Person who becomes covered for dental benefits more than 31 days after he or she was eligible for such coverage will not be covered until the Covered Person has been covered under the Plan for 24 months.

Dental Exclusions and Limitations

The following expenses are excluded from dental benefits:

1. Charges excluded under the General Exclusions and Limitations section of the Plan, unless stated otherwise.

2. Any service or supply covered in whole or in part under the medical provisions of this Plan.

3. Any service or treatment for Cosmetic purposes. The following are always considered to be for Cosmetic purposes:

   a. facings on crowns or pontics posterior to the second bicuspid, and

   b. personalization of dentures.

However, this exclusion does not apply to services required because of Injuries if:

a. the services are rendered within six months after the Accident, and

b. the services are rendered while the person is covered for these dental benefits.

4. Replacement of a lost, missing or stolen prosthetic device or other device or appliance.

5. Appliances, restorations, or procedures for

   a. altering of vertical dimensions,*

   b. restoring or maintaining occlusion,*

   c. splinting,*

   d. correction of attrition or abrasion,

   e. bite registration,

   f. bite analysis, or

   g. treatment of Temporomandibular Joint Syndrome (TMJ).*

   * By other than covered orthodontic treatment

6. Any service or supply not furnished by a dentist, except

   a. a service performed by a dental hygienist working under the supervision of a dentist, and

   b. X-ray order by a dentist.

7. Charges for plaque control programs or instruction in oral hygiene or diet.

8. Replacement within five years of its last placement of any

   a. prosthetic appliance,

   b. crown,

   c. inlay or onlay restoration, or

d. fixed bridge.

However, this exclusion does not apply to any such replacement required because of Injury.

9. Orthodontic services or dental care of a congenital or developmental malformation, unless included in the benefits for orthodontic services.

10. Oral antibiotics

11. Tissue conditioning

12. TMJ Syndrome (orthodontic services)

13. Invisalign

14. Expenses for assignment of dental benefits to a provider outside of the United States will not be considered eligible.

15. Expenses for services or supplies not recognized or recommended by the American Dental Association (ADA) will not be considered eligible.

GENERAL EXCLUSIONS AND LIMITATIONS

Note: See the Prescription Drug Benefit and Dental Benefit sections for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. This Plan excludes or limits coverage as described for the following, unless specifically covered by the Plan or recommended by the United States Preventive Services Task Force (USPSTF) for preventive care:

Occupational Illness or Injury

Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded.

Government Plan

Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

Unnecessary Services or Supplies

Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

Weekend Admissions

If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

Excess of Reasonable and Customary

The portion of any charge for any services or supplies that are in excess of the Reasonable and Customary charge or the Allowable Charge, as determined by the Plan Administrator, is excluded.

Mouth and Teeth Conditions
Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:

1. Treatment or removal of malignant or benign tumors;

2. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three months of the Accident; or

3. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

Foot Conditions
Expenses for routine foot care, treatment of weak, unstable or flat feet will be excluded.

Vision Care
Medical Benefits for Physicians' services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. Radial Keratotomy, LASIK, and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any, or services included in the "Lenses" benefit in the section entitled "Medical Benefits."

Cosmetic or Cosmetic Surgery
Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:

1. Incurred as a result of accidental Injury;

2. For correction of a congenital anomaly; or

3. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant.

Injury Due to Act of War
Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Routine or Preventive Care
Routine or preventive care, including but not limited to immunizations and Routine Physical Examinations, is excluded, except as otherwise specifically listed and included for coverage under this Plan.

Outpatient Well Baby or Well Child Care
Routine well baby or well child care, checkups and immunizations are excluded, except as otherwise specifically listed and included for coverage under this Plan.

Other General Exclusions
Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion**: Elective abortions are excluded unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. However, complications from abortions, whether elective or non-elective, are covered.

2. **Acupuncture/Acupressure**: Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

3. **Administrative fees**, interest or penalties.

4. **Bariatric Surgery**: Unless mandated by federal legislation, a charge for bariatric surgery (including, but not limited to gastric bypass, intestinal bypass, lap band, Roux-en-Y gastroenterostomy, adjustable gastric restrictive procedure, sleeve gastrectomy, gastroplasty, liposuction, or similar surgeries, including the normal pre-surgery and post-surgery care related to those procedures) is excluded except as specifically covered in the "Bariatric Surgery" benefit in the section entitled "Medical Benefits."

5. **Blood** and blood derivatives that are donated or replaced, including fees for administration. Autologous blood donations will be excluded unless the blood is actually used during a scheduled surgery.

6. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

7. **Claim form**: Completion of a claim form.

8. **Cognitive and Kinetic Therapy**: Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major Illness. Office visits to monitor the medications for ADD or ADHD will be covered.

9. **Complications from non-covered services**: Charges that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.

10. **Controlled substances**: Injury or Illness resulting from a Participant'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 Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

11. **Coordination of benefits**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

12. **Coverage not in force**: Charges incurred while coverage is not in force under the Plan.

13. **Custodial** care.

14. **Deductible**: Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.

15. **Developmental Delays**: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, Occupational Therapy, physical therapy and any related diagnostic testing will not be considered eligible. Office visits to monitor the medications for ADD or ADHD will be covered, and as otherwise covered as a preventive service as specified under the Eligible Medical Expenses section of the Plan.

16. **Diabetes** self-management training.

17. **Education**, training, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns.

18. **Electrical power**, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

19. **Emergency Room** charges for a condition that is not an Emergency.

20. **Equipment**: Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.

21. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided.

22. **Family member**: Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.

23. **Fertilization**: Any means of artificial fertilization, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer. Services of a surrogate mother are also excluded.

24. **Foreign Travel**: Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

25. **Genetic testing** or treatment, unless the results are specifically required for a medical treatment decision on the member or as recommended by the United States Preventive Services Task Force (USPSTF).

26. **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.

27. **Homeopathic Treatment**: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

28. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

29. **Illegal Occupation/Felony**: Expenses for treatment received for an Illness or Injury sustained as a result of being engaged in an illegal occupation, sustained while incarcerated, or sustained during the commission of, or the attempted commission of a crime, an assault, felony, misdemeanor or any other illegal act whether or not there is a criminal charge or a conviction of a crime will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

30. **Infertility**: All specific treatments to correct infertility and sterility, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer.

31. **Learning Disabilities**: Expenses, including mental health care, related to the treatment or testing of learning disabilities, developmental disorders, dyslexia, autism or mental retardation or any similar conditions will not be considered eligible. However, office visits to monitor the medications for ADD or ADHD will be covered.

32. **Marriage** counseling.

33. Expenses for **massage therapy** or rolfing.

34. Expenses for **medical marijuana**.

35. **Medicare**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Participants aged 65 or older, and is subject to federal regulation.

36. **Not legally required to pay**: Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.

37. **Not listed**: Any items not listed in "Covered Expenses."

38. **Not necessary**: Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.

39. **Not performed under the direction of a Physician**: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

40. **Obesity**: Unless mandated by federal legislation, treatment of obesity is excluded, except as specifically covered in the "Bariatric Surgery" benefit in the section entitled "Medical Benefits."

41. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

42. **Organ transplants**: Organ transplants other than those specified as covered under the

Plan; or organ transplants that are Experimental or Investigational or which are not approved by the FDA; and

Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan or unless the donor is a covered Participant under the Plan.

43. **Personal** or convenience items.

44. **Physical Fitness**: Programs, services, or equipment related to physical conditioning or weight loss (including but not limited to, surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, exercise programs, or exercise-related equipment, and other services and supplies that are primarily intended to control weight or treat obesity, morbid obesity, or for the purpose of weight reduction) are excluded, regardless of whether the above would also treat any other Injury or Illness.

45. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

46. **Prison**: Charges for services received while confined in a prison, jail or other penal institution.

47. **Private duty nursing** care.

48. **Radioactive contamination**: An Injury or Illness caused as a result of radioactive contamination.

49. **Riot/Revolt**: Expenses resulting from a Participant's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

50. Expenses for **reversal surgery** of any kind.

51. **Room and board** for any other room at the same time the patient is being charged for use of a special care unit.

52. **Sales tax** on prescription drugs or on any other covered items.

53. **Scheduled visit**: Failure to keep a scheduled medical visit.

54. **Sexual dysfunctions**, impotence, penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.

55. **Sleep disorders**: Expenses for treatment, services and supplies for sleep disorders, charges related to the diagnosis and treatment of sleep disorders will not be considered eligible, except in the case of sleep apnea.

56. **Smoking cessation:** Care and treatment for smoking cessation, including programs, smoking deterrent patches, nicotine gum or other deterrents, except as recommended by the United States Preventive Services Task Force (USPSTF).

57. **Speech therapy** for developmental delay, to change voice sound, stuttering, stammering, myofunctional or conditions of psychoneurotic origin.

58. **Sterilization reversal**: Reversal of previous sterilization treatments or surgeries.

59. **Surrogate**: Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses, will not be considered eligible.

60. **Telephone** conversations with a Physician.

61. Treatment of **Temporomandibular Joint syndrome**, whether surgical or nonsurgical.

62. **Travel expenses**, even if prescribed by a Physician.

63. **VAX-D** therapy.

64. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

65. **Vision therapy** (nonsurgical treatment to the eye muscles).

66. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a Physician, unless specifically covered herein.

67. **Wig** after chemotherapy.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a General Information Verification Form to verify continued eligibility for benefits. If you need a General Information Verification Form, you may download one from the Gilsbar website at www.myGilsbar.com or you may notify your Human Resources Department.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the patient's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to the Exclusive Provider Organization, must be received by Gilsbar, L.L.C. no later than 12 months after the date the expense is Incurred. A claim received after this deadline will be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, L.L.C. to be sure the Claims Department has received all submitted claims.

CLAIMS PAYMENT AND APPEALS

Assignability

Benefits for Covered Expenses may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Claims Procedure

A description of the Plan's process for handling claims and appeals for health, prescription drug, and dental benefits follows. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan's procedures, which are described below. "Days" means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials: Pre-service Claim, Concurrent Claim, and Post-service Claim. The definitions and procedures for the three types of health claims are:

Pre-service Claim – a claim for a benefit under the Plan where prior approval for any part of the benefit is a condition to receiving the benefit. If a Participant makes a request for information on a charge or benefit (or a request for a determination of Medical Necessity) for which prior approval is not required by the Plan, that informational request or determination is not a pre-service claim. If a Participant needs medical care for a condition which could seriously jeopardize his life, health or ability to regain maximum function or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to seek or obtain approval in advance of obtaining medical care. The Participant should obtain such care without delay and contact the Utilization Management (UM) organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an on-going course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated, or
2. the Participant requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require approval, then there is no need to contact the UM organization to request an extension of that treatment.

Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for approval is made and received by the UM organization or Benefit Services Manager in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant.

If the Plan contracts with an EPO network and you receive care through an in-network (EPO) provider, you will not need to file a medical claim. On your first visit to your network provider, you will sign a form to assign benefits to that provider, and they will file the claims on your behalf.

If you receive care through an out-of-network (non-EPO) provider and those services are covered as specifically described in the section entitled "Exclusive Provider Organization," you will be responsible for filing your own claims, although some out-of-network providers may file claims on your behalf.

A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92 or successor forms, or an Electronic Data Interchange (EDI) file or other standard billing format;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee;
9. The name of the patient; and
10. Any Physician's notes, accident details, employment status, coordination of benefits information, or other information needed to adjudicate the claim.

When the information referenced above is provided, the claim is considered a "Clean Claim". The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If the claim is not a Clean Claim, the Plan may deny the claim or may take an extension of time in order to request additional information. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant or the authorized

representative receives the request. **Failure to respond within this time period may result in claims being denied or reduced.**

"Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. It includes any reduction or failure to make payment resulting from the application of any utilization review, the application of any Plan exclusions, and the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

Timing of Notice of Benefit Determinations:
Pre-service Claim:

1. If the Participant has provided all the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).

3. If the Participant has failed to follow the Plan's procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.

4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), it will do so before the end of such period of time or number of treatments.

The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. Request by Participant for Extension of Treatment. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim or Post-service Claim and decided within the timeframe appropriate to that type of claim.

Post-service Claim:

1. If the Participant has provided all the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

3. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Form of Notice to Participant of Adverse Benefit Determinations

Once the claim has been decided, the Plan Administrator will provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

1. The reason or reasons for the Adverse Benefit Determination;
2. Reference to the Plan provisions on which the determination was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a denial of the appeal;

5. A statement that the Participant is entitled to request the diagnostic and treatment codes used and their meaning;
6. A statement that any rule, guideline, protocol, or criterion that was relied upon in making the Adverse Benefit Determination will be provided free of charge to the Participant upon request;
7. If the denial is based on Medical Necessity, Experimental/Investigational Treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Procedure for Internal Appeals

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant 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 that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information will 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. Demonstrates 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 Participants; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant's responsibility to submit proof that the claim for benefits is covered and payable under the Plan's provisions. Any appeal must include the following:

1. The name of the Covered Employee/Participant;

2. The Covered Employee's/Participant's social security number or Participant ID number (PID);
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits, whether or not presented or available at the initial benefit decision. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not rely on the initial Adverse Benefit Determination and will be conducted by the Plan Administrator, who is neither the individual who made the Adverse Benefit 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 Plan Administrator will consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. 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 upon request.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice of determination. The notice will meet the requirements as described above.

The Plan Administrator will notify the Participant of the Plan's benefit determination on review within the following timeframes:

Pre-service and Concurrent Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

This Plan does not require prior approval for a Participant to receive urgent care; therefore, all urgent care claims will be handled as Concurrent or Post-service claims.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Responsibility for Deciding Claims and Appeals

The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the provisions in this section and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. Processing claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilsbar, L.L.C.

Decision on Appeal to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed and the decision on the appeal has been rendered by the Plan Administrator. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables

This chart of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section and applicable subsections carefully for complete information regarding the timetables that apply to your claim.

Time Limits	Type of Claim			
	Pre-Service	**Concurrent: To end or reduce treatment prematurely**	**Concurrent: To deny your request to extend treatment**	**Post-Service**
You'll be notified of determination as soon as possible, but no later than…	15 days from receipt of claim	Notification to end or reduce will allow time to finalize appeal before end of treatment	Treated as any other pre-service or post-service claim	30 days from receipt of claim
Extension period allowed for circumstances beyond the Benefit Services Manager's control…	15 days	n/a	Treated as any other pre-service or post-service claim	15 days

Time Limits	Type of Claim			
	Pre-Service	**Concurrent: To end or reduce treatment prematurely**	**Concurrent: To deny your request to extend treatment**	**Post-Service**
If additional information is needed, you must provide it within…	45 days of date of extension notice	n/a	Treated as any other pre-service or post-service claim	45 days of date of extension notice
You must file your appeal within…	180 days of claim denial	Denial letter will specify filing limit	Treated as any other pre-service or post-service claim	180 days of claim denial
You'll be notified of the appeal decision as soon as possible but no later than…	30 days from receipt of appeal	15 days from receipt of appeal	Treated as any other pre-service or post-service claim	60 days from receipt of appeal

Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from Gilsbar, L.L.C. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

An Appointment of Authorized Representative Form may be obtained from www.myGilsbar.com or by calling the number below and forms must be submitted to:

Gilsbar, L.L.C.
Attention: Claims Dept.
P.O. Box 998
Covington, LA 70433
Phone: 1-888-472-4352
Fax: 985-898-1529

Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any

such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.

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

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition

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

2. Plan Participant(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from

any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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

Subrogation

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

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

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

    a) the responsible party, its insurer, or any other source on behalf of that party;

    b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

c) any policy of insurance from any insurance company or guarantor of a third party;

d) worker's compensation or other liability insurance company; or,

e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

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

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

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of

subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

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

   The Plan's benefits shall be excess to:

   a) the responsible party, its insurer, or any other source on behalf of that party;

   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

   c) any policy of insurance from any insurance company or guarantor of a third party;

   d) worker's compensation or other liability insurance company or

   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

1. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

1. In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

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

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

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

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

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

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

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

Offset

1. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

2. Future claims may not be paid until all funds owed to the Plan have been reimbursed. The Plan may, at its discretion, offset any liens not fully reimbursed against any future medical claims until the Participant(s) satisfies his or her obligations.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

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

Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

1. In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COORDINATION WITH OTHER PLANS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed one hundred percent (100%) of the Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called "coordination of benefits." Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan were to provide coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits as permitted by law.

As permitted by law, this Plan also will be the secondary payor and will coordinate its benefits with Medicare for Participants who are eligible to enroll in Medicare due to disability or End Stage Renal Disease (whether or not you are enrolled for such coverage). For Participants with End Stage Renal Disease, the Plan will pay the Allowable Charge for the first 90 days. After the first 90 days, the Plan will pay according to Medicare's published fee schedule.

For the purposes of this coordination provision, the term "plan" means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and

2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and college students. This does not include any law or plan where benefits are provided after those provided by other plans.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan (as described below) pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);

2. If a child is covered under both parents' plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:

    a. the plan of the parent with custody of the child;

    b. the plan of the Spouse of the parent with custody of the child;

    c. the plan of the parent not having custody of the child; and

    d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Allowable Charge shall be shared equally between the plans.

TERMINATION OF COVERAGE

Coverage will terminate for an employee at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Last day of the month in which employment terminates;

3. Last day of the month in which employee ceases to be an Eligible Employee (unless the employee is in a Stability Period or Administrative Period);

4. Last day of the employee's current Stability Period or the Administrative Period (if applicable), if the employee does not meet the requirements for future coverage as determined by the current Standard Measurement Period;

5. Date the employee chooses Medicare as his sole coverage;

6. The end of the last period for which any required contribution was received;

7. Date of the employee's death; or

8. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Date the employee's coverage terminates;

3. Date the dependent enters active service with armed forces of any country;

4. Last day of the month in which the dependent ceases to be an Eligible Dependent;

5. Date the dependent chooses Medicare as his sole coverage;

6. For a dependent Spouse, on the date of divorce or legal separation;

7. For a dependent child/children, the end of the month of attainment of the applicable age limit;

8. The end of the last period for which any required contribution was received; or

9. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

Continuation of Benefits

If a Covered Employee ceases active employment due to an authorized leave of absence, participation may be continued for a maximum of 90 days (unless additional time is approved by the Plan Administrator), pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all employees similarly situated.

Where coverage is continued under this provision, it shall not be in addition to the continuation period required under the Family and Medical Leave Act, but shall run concurrently with FMLA leave.

Reinstatement of Coverage

A Covered Employee whose employment terminates and who is rehired within 90 days will be eligible for coverage on the first of the month following the date he/she completes at least one hour of service or the date he returns to work directly from COBRA coverage. The waiting period will not apply provided he meets all the other requirements of the definition of an Eligible Employee. Participants whose coverage is reinstated under this provision will receive credit for any portion of the Calendar Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Continuation During Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

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

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

What is a Qualifying Event?
Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or

2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;

2. Your Spouse's hours of employment are reduced;

3. Your Spouse's employment ends for any reason other than his or her gross misconduct;

4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;

2. The parent-Covered Employee's hours of employment are reduced;

3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

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

The Employer must give notice of some Qualifying Events
When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events
Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (928) 679-4279:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;

3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;

4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and

5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Northern Arizona Council of Governments
Plan Administrator
119 East Aspen Avenue
Flagstaff, Arizona 86001-5222
(928) 774-1895

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

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

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

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

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

1. Name and address of the Covered Employee or former employee;

2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;

3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);

4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age);

7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

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

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the

SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

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

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

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

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?
COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a group health plan to any employee;

2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first); or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Northern Arizona Council of Governments
Plan Administrator
119 East Aspen Avenue
Flagstaff, Arizona 86001-5222
(928) 774-1895

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and

2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

3. You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;

2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?
Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:

    a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:

        i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or

        ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

    b. For leaves of 31 to 180 days, by submitting an application for reemployment with your Employer:

        i. Not later than 14 days after completing uniformed service; or

        ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.

    c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.

    d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?
The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your Employer.

PLAN ADMINISTRATION

The Plan Administrator

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of Gilsbar, L.L.C., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator's relationship with Gilsbar, L.L.C. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and what charges are Reasonable and Customary), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a covered person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a benefit services manager to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan's administration.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's articles of incorporation or bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses

All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.

Notices

All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity

In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

HIPAA PRIVACY

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as Required by Law (as defined in the Privacy Standards);

- Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or group employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

    Appropriate personnel of the Human Resources department

    Appropriate personnel of the Finance department

  - The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

  - In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

The following is included in the Plan:

1. Definitions

   Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

   Security Incident – The term "Security Incident" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Plan Sponsor Obligations

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

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
  - Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
  - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a Medical Child Support Order

or a National Medical Support Notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

IMPORTANT NOTICE

NOTICE OF PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Northern Arizona Council of Governments and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or Participating Provider) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. It has determined that the prescription drug coverage offered by the Northern Arizona Council of Governments is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
Your current medical coverage pays for other health expenses in addition to prescription drugs. If you and/or your dependents enroll in a Medicare drug plan, you and/or your dependents will still be eligible to receive medical and prescription drug benefits through Northern Arizona Council of Governments. If you and/or your dependents enroll in a Medicare drug plan, in general, the following guidelines listed below apply. If you are an active Member, or the covered dependent of an active Member, you are required to obtain your outpatient prescription drug benefits through your Northern Arizona Council of Governments plan first. You can then file on a secondary basis with your Medicare drug plan.

If you are a COBRA participant, or the covered dependent of a COBRA participant, you are required to obtain your outpatient prescription drugs through your Medicare drug plan first. Secondary coverage is not available through Northern Arizona Council of Governments.

Important: You can only waive prescription drug coverage by waiving the entire Northern Arizona Council of Governments medical/prescription plan coverage for yourself and your dependents. Remember, if you do waive your Northern Arizona Council of Governments coverage, you can only re-enroll in the Northern Arizona Council of Governments medical plan coverage during the next Open Enrollment Period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Northern Arizona Council of Governments and don't join a Medicare drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Northern Arizona Council of Governments changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Northern Arizona Council of Governments, 119 East Aspen Avenue, Flagstaff, Arizona 86001-5222, (928) 774-1895.

OTHER INFORMATION

Plan Name	NACOG Employee Benefit Plan
Plan Number	501
SFP Number	S-2724
State of Organization	Northern Arizona Council of Governments is organized under the laws of the State of Arizona.
Plan Sponsor	Northern Arizona Council of Governments 119 East Aspen Avenue Flagstaff, Arizona 86001-5222 (928) 774-1895
Tax Identification Number	86-0262631
Plan Administrator	Northern Arizona Council of Governments 119 East Aspen Avenue Flagstaff, Arizona 86001-5222 (928) 774-1895
Plan Affiliates/Subsidiaries	None
Benefit Services Manager	Gilsbar, L.L.C. P.O. Box 998 Covington, LA 70434 Telephone (985) 892-3520 or (800) 445-7227 Fax (985) 898-1500
Type of Plan and Administration	This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.
Plan Year Ends	December 31

Plan Cost	Employer pays the cost of employee coverage under this Plan.* The Covered Employees pay the entire cost for coverage for their dependents. *However, coverage for dental benefits is elected separately from medical benefits, and employee contribution may be required for employee and dependent coverage. 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.
Benefits	Plan benefits are provided by Northern Arizona Council of Governments.
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan is Not an Employment Contract	The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.
Effective Date	This Plan was adopted by Northern Arizona Council of Governments effective January 1, 2015, and has been restated in this updated Plan Document and summary Plan description. The effective date of this amendment of the Plan is January 1, 2016.

NACOG EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Northern Arizona Council of Governments, a corporation having established the NACOG Employee Benefit Plan for the benefit of Eligible Employees on the terms and conditions described in the Plan Document and Summary Plan Description originally effective January 1, 2015, hereby amends and restates that NACOG Employee Benefit Plan, including any amendments that were effective at the time of this restatement, to read as stated in this updated Plan Document and Summary Plan Description.

The effective date of this amendment is January 1, 2016.

NOW, THEREFORE, The NACOG Employee Benefit Plan is hereby adopted to read as described in the following attached exhibit:

The NACOG Employee Benefit Plan, Plan Document and Summary Plan Description

IN WITNESS WHEREOF, this adoption document has been executed by or on behalf of the Plan Sponsor, duly authorized, effective on the day and year stated above.

NORTHERN ARIZONA COUNCIL OF GOVERNMENTS, PLAN SPONSOR

WITNESS:_____

BY:_____

DATE:_____

TITLE:_____