



B O T E T O U R T

C O U N T Y O F V I R G I N I A

SUMMARY PLAN DESCRIPTION

for

Plan Participants

of

Botetourt County

Employee Benefit Plan

Revised and Restated December 1, 2015

NOTICE

The enclosed Schedule of Benefits is an outline of benefits of the Botetourt County Employee Benefit Plan provided by your Employer. The basis of payment of the benefits described in this Schedule of Benefits will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the determination that care and treatment is Medically Necessary; that charges are Usual and Reasonable; and that services, supplies and care are not Experimental and / or Investigative.

This Summary Plan Description contains a summary in English of your Plan rights and benefits under your Group Health Plan. If you speak Spanish only and have difficulty understanding any part of the Summary Plan Description, contact MedCost Benefit Services for Customer Service at (800) 795-1023. Office hours are from 8:30 a.m. to 5:00 p.m. (Eastern Time) Monday through Friday.

Esta Descripción del Plan del Resumen contiene un resumen en inglés de sus derechos de Plan y beneficios bajo su Plan de la Salud del Grupo. Si usted habla español sólo y tiene la comprensión de dificultad cualquier parte de la Descripción del Plan del Resumen, el Servicio de atención al cliente de MB de contacto en (800) 795-1023. Las horas de oficina son de 8:30 de la mañana a 5:00 de la tarde. (Tiempo oriental) el lunes por el viernes.

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INTRODUCTION

Note to Plan Participants

- Capitalized terms have specific meanings when used in this document. The meanings of these capitalized terms are in the *Defined Terms* section of this document.
- This Summary Plan Description describes the circumstances when this Plan pays for health care. All decisions regarding health care are up to the Plan Participant and his or her Physician. There may be circumstances when a Plan Participant and his or her Physician determine that health care, which is not covered by this Plan, is appropriate. The Plan Sponsor does not provide nor ensure quality of care.
- Changes in the Plan may occur in any or all parts of the Plan including, but not limited to, benefit coverage, deductibles, maximums, copays, exclusions, limitations, definitions and eligibility.
- The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.
- If the Plan is terminated, amended, or benefits are eliminated, the rights of Plan Participants are limited to Covered Charges incurred before termination, amendment or elimination.

Purpose

This document is a Summary Plan Description of *Botetourt County Employee Benefit Plan* (the Plan).

- The Plan described is designed to protect Plan Participants against certain health expenses.
- The Plan Sponsor established this Plan to provide for the payment or reimbursement of covered health expenses incurred by Plan Participants.
- The Plan is not to be construed as a contract for or a guarantee of employment. Nothing in this Plan shall be deemed to:
 - Affect the right of the Employer to discipline or discharge any Employee at any time.
 - Affect the right of any Employee to terminate his or her employment at any time.
 - Give the Employer the right to require any Employee to remain in its employ.
 - Give any Employee the right to be retained in the employ of the Employer.

Exclusive Benefit

- This Plan is established and shall be maintained for the exclusive benefit of eligible Plan Participants.
- The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.
- Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.
- No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of an error, an adjustment of any benefits paid will be made.

Compliance / Limitation

- This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. No oral interpretations can change this Plan.
- No action at law or in equity shall be brought to recover any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.
- No action at law or in equity can be brought to recover after the expiration of three (3) years after time when written proof of loss is required to be furnished to the Third Party Administrator.
- Failure to follow the eligibility or enrollment requirements, including timely application for coverage of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other health management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.
- Should any part of this Benefit Summary Description for any reason be declared invalid, such decision shall not affect the validity of the remaining portion, which remaining portion shall remain in effect as if this Benefit Summary Description has been executed with the invalid portion thereof eliminated.

Document Sections

This summary plan document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

- *Schedule of Benefits* - Provides a description of covered medical expenses and explains when the benefit applies.
- *General Provisions* - Explains Employee and Dependent eligibility for coverage under the Plan, funding of the Plan, Special Enrollment Rights and when the coverage takes effect and terminates.
- *Health Management Services* - Explains the Plan's programs used to help Plan Participants curb unnecessary and excessive charges, Plan Participant's responsibilities for health management, and possible penalties that may be assessed for failure to follow Health Management requirements.
- *Coverage of Medical Expenses* - Explains the Plan's payment or reimbursement as well as limits on certain services.
- *Medical Benefit Exclusions* - Provides a list of what charges are not covered.
- *Prescription Drug Benefits, Limitations & Exclusions.*
- *Claims Procedures and Appeals* - Describes how to submit a claim, how the Plan processes claims and explains the rules of the claim appeal process.
- *Coordination of Benefits* - Shows the Plan order of payment when a Plan Participant is covered under more than one plan.
- *Reimbursement and/or Subrogation* - Explains the Plan's rights to recover payment of charges when a Plan Participant has a claim against another person or entity because of injuries sustained.
- *Continuation Coverage Rights Under COBRA* - Explains the continuation options that are available when a Plan Participant's coverage under the Plan ceases.
- *Defined Terms* - Defines those Plan terms that have a specific meaning.
- *Notice of Privacy Practices* - Explains how the Plan may use and disclose a Plan Participant's Protected Health Information (PHI) in addition to the restrictions placed on such use and disclosure

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call toll-free (800) 795-1023. All calls are strictly confidential.

**SCHEDULE OF BENEFITS
2015**

For access to information 24/7, go to www.medcost.com and go to Member Login to visit the personalized website; use ID card with Member and Group ID numbers to create an account. For questions about claim status, benefits or other general questions, contact MedCost Benefit Services Customer Service at (800) 795-1023 or mbscs@medcost.com; please include Member ID in body of email.

This Schedule of Benefits is an outline of benefits of the Employee Benefit Plan provided by your Employer. The basis of payment of the benefits described in this Schedule of Benefits will be determined by the provider of services and claims rules of the Plan. All benefits described in this Schedule are subject to the exclusions and limitations described more fully in the remainder of the Summary Plan Description.

See details of the following highlights in remainder of the Summary Plan Description.

Waiting Period / Effective Date (<i>New Hires</i>)	1 st of the month following 30 days of continuous, full-time employment with the Employer
Waiting Period (<i>Rehires</i>)	A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or her termination date will not be required to satisfy the Employer's Waiting Period.
Measurement Period	This Plan's Measurement Period is October 1 st through September 30 th .
Stability Period	This Plan's Stability Period is December 1 st through November 30 th .
Spousal Definition	<p>"Spouse" shall mean a person of the opposite gender or same gender who is legally recognized as the husband or wife under the laws of the state where the marriage took place. The Employer may require documentation proving a legal marital relationship.</p> <p><i>Note: The Plan does not offer coverage to a same gender domestic partner, opposite gender domestic partner or a common-law spouse, even if the state in which the Employee lives recognizes such a partnership.</i></p> <p><i>Note: Please refer to the Human Resources Department if your spouse is eligible for other employer-based coverage.</i></p>
Dependent Children	Coverage will end the end of the month during which the Dependent child's 26 th birthday occurs.
Retirees	Eligible to age 65 or Medicare eligible
Open Enrollment	Benefit choices made during Open Enrollment are effective on December 1 st .
Leave of Absence	FMLA. See remainder of Summary Plan Description.
Pre-Existing Conditions	This Plan does not apply a Pre-Existing Conditions Exclusion Period to any member.

Network and Health Management

Network	VHN Plus and AHA
Out-of-Area / Travel Network	AHA Option 1 National
Precertification	<ul style="list-style-type: none"> • Hospital admissions* • Hospital observation unit stays of more than 48 hours • Certain diagnostic services rendered as Outpatient or in Physician's Office (see Outpatient Review)** • Dialysis services***
<i>Penalty</i>	<p>*Non-precertified Room and Board charges will be denied. **Non-precertified diagnostic services listed under Outpatient Review will be denied. ***Failure to precertify dialysis will result in associated charges from the first treatment date being denied.</p>
Outpatient Review	Precertification is required for MRI, CT and PET scans performed Outpatient or in Physician's office. Services performed in emergent situations (to rule out need for surgery or urgent treatment) are not subject to the requirement for Outpatient Review / Precertification.
Case Management	Case Management is a program that provides special intervention during care or treatment for serious illnesses and accidents.

Benefit Maximums / Annual Deductible / Out-of-Pocket

This Plan does not apply a Lifetime or Annual Benefit Maximum to each Plan Participant for the total claim

expenses incurred and paid while covered under this Plan.			
		<i>In-Network</i>	<i>Non-Network</i>
Annual Deductible	<i>Individual</i>	\$0	\$10,000
	<i>Family</i>	\$0	\$20,000
Network and Non-Network deductibles DO NOT accumulate towards each other.			
Out-of-Pocket Maximum	<i>Individual</i>	\$4,500	\$20,000
	<i>Family</i>	\$9,000	\$40,000
Out-of-Pocket Maximum INCLUDES all cost sharing EXCEPT health management penalties.			
Network and Non-Network Out-of-Pocket Maximums DO accumulate towards each other.			
Benefit Year	December 1 st through November 30 th		
Inpatient Hospital Services			
		<i>In-Network</i>	<i>Non-Network</i>
Room and Board		70%	50% after deductible
	Includes the medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center; after 48 observation hours, a confinement will be considered an inpatient confinement and will require precertification. If you occupy a private Hospital room, you will pay the difference between the Hospital's charges for a private room and the charge for a semiprivate room. If the Hospital does not have semiprivate rooms or a semiprivate room is unavailable, or your medical condition requires a private room (as determined by the Claims Administrator), the Plan will consider the private room rate. Payment for Critical Care Room and Board will be based on the Hospital's ICU charge.		
Physician Inpatient Services		70%	50% after deductible
	The Plan covers professional services of a Physician for Inpatient surgical or medical services. When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard practices. Benefits will be based on 20% of the allowable expense or billed charge.		
Other Inpatient Services		70%	50% after deductible
Emergency and Urgent Care Services			
		<i>In-Network</i>	<i>Non-Network</i>
Emergency Room Treatment <i>including related services</i>		70%	
Urgent Care		As any office visit	As any office visit
Outpatient Hospital Services			
		<i>In-Network</i>	<i>Non-Network</i>
Pre-Admission Testing		70%	50% after deductible
	The Plan will pay for diagnostic tests and X-rays when performed on an outpatient basis before a Hospital admission, provided the procedures are provided within 7 days of the admission, are related to the condition that causes the admission and are performed in lieu of tests while Hospital confined. Payment will be made even if tests show that the condition requires medical treatment prior to Hospital admission or the Hospital admission is not required.		
Outpatient / Ambulatory Surgery <i>Facility / Surgeon</i>		70%	50% after deductible
	When multiple procedures are performed during the same operative session, benefits will be based on Medically Necessary services. Allowable expenses will be determined based on the complexity of the procedures. 100% of the allowable expense for the most complex will be considered and 50% of the allowable expense or billed charge will be considered for each additional procedure. An assistant surgeon will be considered eligible when Medical Necessity has been determined based on standard		

	practices. Benefits will be based on 20% of the allowable expense or billed charge.	
Outpatient Laboratory & X-Ray Services	70%	50% after deductible
Outpatient Diagnostic Scans <i>MRI, CT, PET</i> <i>Precertification required</i>	70%	50% after deductible
	See Advanced Imaging under Other Services for benefit for Insight Advanced Imaging.	
Other Outpatient Services	70%	50% after deductible
Physician Services		
	In-Network	Non-Network
Office Visit for Injury / Illness		
<i>Primary Care</i>	\$20 copay per office visit	50% after deductible
	General practitioner, family practitioner, internist, pediatrician and OB-GYN.	
<i>Specialist</i>	70%	50% after deductible
	Office visit covers most services, including Office Labs and X-rays, performed in and billed by the Network Physician's office.	
<i>Not covered as part of the office visit:</i>	Services not covered as part of the office visit include, but are not limited to: high cost injections, infusion therapy, outpatient laboratory and X-ray services, MRI, CT scan, PET scan, chemotherapy, radiation therapy, dialysis services, prenatal and postnatal Physician visits, physical therapy, speech therapy, occupational therapy, sleep studies and TMJ services/supplies.	
Office Laboratory & X-Ray Services	As any office visit <i>(Please contact Customer Service for details, if needed.)</i>	As any office visit <i>(Please contact Customer Service for details, if needed.)</i>
Office Surgery	70%	50% after deductible
Second Surgical Opinions	As any office visit	As any office visit
	Benefits will be provided to determine the Medical Necessity of an elective surgical procedure. The second opinion must be made by a board-certified Physician who is affiliated in the appropriate specialty, and who is not an associate of the attending Physician.	
Routine Wellness / Preventive Services		
	In-Network	Non-Network
Routine Wellness / Preventive Services	100%	50% after deductible
	<p><i>Includes Physical or Gynecological exam</i>, well child care, laboratory services, X-ray services, immunizations / vaccines / flu shots, health history, developmental assessment, colorectal screening, pap smear, ovarian cancer screenings, PSAs, bone mass measurements, and contraceptive management. Contraceptive management includes FDA approved contraceptive methods, sterilization procedures, and education and counseling for women. Devices, injectables, oral contraceptives, patches, vaginal rings, and implants are covered under the Prescription drug card. Excludes over-the-counter products. Gynecologists may perform the Gynecological exam and pap smear, with the balance of the physical exam performed by another Physician. There will be no duplication of services. <i>See also Advanced Cancer Screening.</i></p> <p>The <i>Patient Protection and Affordable Care Act (PPACA)</i>, as part of Health Care Reform, contains a provision that requires your health plan to provide certain preventive care services with no cost-sharing, i.e., not subject to copays, coinsurance, or deductibles. * These services include, but are not limited to: Routine physicals; Pediatric wellness examination; Selected preventive, diagnostic, and cancer screenings; and Certain Pediatric Preventive Services, including but not limited to, oral health assessment, sensory screening, and developmental and behavioral assessment.</p> <p>These preventive services are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations please visit: https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p> <p><i>Preventive Services for Women without cost share</i></p>	

	<p>(The following list is not all-inclusive.)</p> <ul style="list-style-type: none"> Well-woman visits: Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including prenatal visits billed outside of global obstetric care. Screening for gestational diabetes. Testing for human papillomavirus (HPV test) annually or as recommended by physician. Sterilization procedures and associated services rendered on the same day (Reversal procedures are not covered). Breastfeeding support and associated supplies and counseling. (Includes lactation support and counseling provided by a trained provider in conjunction with birth; also includes purchase, or rental cost up to purchase price, of breastfeeding equipment from a network provider if available. Purchase is limited to one per pregnancy and purchase from a retail store is not covered.) Screening and counseling for interpersonal and domestic violence <p>These preventive services for women are covered based on recommendations of the independent Institute of Medicine and supported by the Health Resources and Services Administration. <i>Unless otherwise stated in this Summary Plan Description, these services are provided with no cost-sharing for adult women only. See Defined Terms.</i></p> <p>The services shown under this section, “<i>Routine Wellness / Preventive Services</i>,” are covered based on the guidelines and recommendations of the United States Preventive Services Task Force (USPSTF). For a complete listing of these guidelines and recommendations, please visit: https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p> <p>*A plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for which a recommended preventive service will be available without cost-sharing to the extent not specified in a recommendation or guideline.</p>	
Advanced Cancer Screening	100%	50% after deductible
	Includes Mammograms and Colonoscopies other than inpatient. Includes routine, diagnostic / therapeutic and related services. Includes polyp removal during routine colonoscopy when billed properly by the provider.	
Nutritional Counseling	100%	50% after deductible
<i>Other than Diabetes Care Management and non-surgical treatment of obesity / Morbid Obesity</i>	Includes medical nutritional counseling, up to 6 visits per Benefit Year, rendered by a licensed health care provider (in-network when available), as required to provide appropriate guidance and education for diet related conditions or risk factors, including but not limited to diabetes, obesity, high cholesterol and high blood pressure.	
Other Services		
	<i>In-Network</i>	<i>Non-Network</i>
Advanced Imaging	70%	50% after deductible
<i>MRI, CT, PET scans</i>		
<i>Precertification required</i>		
<i>Insight Advanced Imaging</i>	80%	Not applicable
Allergy Services	As any office visit	As any office visit
<i>Testing / Treatment</i>	The Plan will pay for Medically Necessary tests to determine the nature of allergies and for desensitization treatment (allergy “shots”) to treat allergies. Test and treatment materials are included and paid according to Plan provisions.	
Ambulance, Air	70%	
<i>Precertification required when non-emergent</i>	Benefits are for Medically Necessary professional air ambulance services. A charge for this item will be a Covered Charge when services are provided by, and in, an air ambulance traveling from the site of an emergency to a Hospital when such a facility is the closest one that can provide covered services appropriate to the Plan Participant’s condition, unless the Plan Administrator finds a longer trip is Medically Necessary. Non-emergency air ambulance services are eligible for coverage only when ground	

	transportation is not medically appropriate due to the severity of the Injury or Illness, or the pick-up point is inaccessible by land, and such services are precertified. Non-emergency air ambulance services require verification of Medical Necessity or services will not be covered.	
Ambulance, Ground	70%	
	Benefits are for local Medically Necessary professional ground ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip is Medically Necessary. The Plan covers services in a ground ambulance traveling: <ul style="list-style-type: none"> • from a Plan Participant's home, scene of an Accident, or site of an emergency to a Hospital; • between Hospitals; and • between a Hospital and a Skilled Nursing Facility when such a facility is the closest one that can provide covered services appropriate to the Plan Participant's condition. Benefits may also be provided for ambulance services from a Hospital or Skilled Nursing Facility to a Plan Participant's home when this is Medically Necessary. 	
Cardiac Rehabilitation	70%	50% after deductible
	Benefit limited to maximum 18 outpatient visits per condition. Cardiac rehabilitation is covered as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.	
Chemotherapy / Radiation	70%	50% after deductible
	Benefit includes treatment with radioactive substances as well as materials and services of technicians.	
Chiropractic Services	70%	50% after deductible
	Benefits limited to Benefit Year maximum of 10 visits. Benefits covered when performed by a licensed M.D., D.O. or D.C.; the following services are not within the scope of a chiropractor's scope of practice and are excluded by the Plan: administering or prescribing medicine or drugs; the practice of osteopathy; diagnostic services and surgery.	
Diabetes Care Management <i>other than Nutritional Counseling</i>	70%	50% after deductible
	The Plan will provide coverage for Medically Necessary diabetes self-management training and educational services.	
Dialysis Management Program <i>Other than Inpatient - Precertification required</i>	70%	
	Failure to precertify dialysis will result in associated charges from the first treatment date being denied. Charges for professional fees and services, supplies, medications, labs and facility fees related to outpatient dialysis are covered expenses. These services include but are not limited to hemodialysis, home hemodialysis, peritoneal dialysis and hemofiltration. Effective December 1, 2014, the Plan will allow billed charges at the defined benefit in the Schedule of Benefits for 42 outpatient dialysis treatments. This Plan does not provide network level benefits for dialysis providers; therefore, benefits are not subject to discount arrangements that the provider may have in place with any network. For subsequent treatments the Plan allowable for dialysis will be limited to 140% of current year Medicare composite allowable. The Plan will pay according to the schedule for the next 30 consecutive months of dialysis or until the Plan is secondary to other coverage, whichever occurs first. Thereafter, as permitted in 42 CFR § 411.161(c) and (d), Medicare will be the primary payer and the Plan will only pay secondary to Medicare or other coverage. The Plan will reimburse Medicare Part B premiums for the individual if and for as long as enrolled in Medicare Part B and receiving benefits under this provision.	

	(Note: Medicare Part B premiums shall be reimbursed quarterly.)	
Durable Medical Equipment	70%	50% after deductible
	The Plan has benefits for the rental of Durable Medical Equipment (DME) if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. DME includes, but is not limited to, apnea monitors, glucometers, oxygen equipment, Hospital type beds and wheelchairs.	
Home Health Care	70%	50% after deductible
	Benefits limited to Benefit Year maximum of 90 visits. Services and supplies are covered only for care and treatment of an Injury or Illness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care maximum stated above. A home health care visit means a visit by a member of a home health care team. Each visit that lasts for a period of 4 hours or less is treated as one home health care visit. If the visit exceeds 4 hours, each period of 4 hours is treated as one visit, and any part of a 4-hour period that remains is treated as one home visit. Private duty nursing is covered when performed by a licensed nurse (R.N., L.P.N. or L.V.N.) and only when care is Medically Necessary, is not Custodial in nature and the Hospital's Intensive Care Unit is filled, or the Hospital has no Intensive Care Unit. The only charges covered for Outpatient nursing care are those shown under Home Health Care. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.	
Hospice Care	70%	50% after deductible
	Hospice care can provide the physical, psychological, spiritual and social support needed to help terminally ill patients and their families cope with the Illness. Care includes services provided by a Hospice program in the patient's home, a Hospital or a Hospice. These services are covered as long as they are prescribed by a Physician and the covered patient's life expectancy is six months or less. Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Employee, covered Spouse and/or covered Dependent Children) are covered. Bereavement services must be furnished within six months following the patient's death.	
Independent Laboratory and X-Ray Services	70%	50% after deductible
	Other than Inpatient and Office	
Infertility Services	As any Covered medical expense	As any Covered medical expense
	The Plan will cover diagnostic services to determine the cause of infertility. Treatment is not covered. Infertility Services are available to the covered Employee and covered Spouse only.	
Injectables and Infusion Therapy <i>See also Office Visit or Allergy Services</i>	70%	50% after deductible
	May exclude high cost specialty drugs that must be purchased and dispensed under the Specialty Pharmacy Benefit. <i>See Prescription Drug Benefits, Limitations & Exclusions</i> for details. <i>These drugs may not be covered by the medical benefits.</i>	
Medical Supplies	70%	50% after deductible
Maternity Care Services		
<i>Physician</i>	70%	50% after deductible
<i>Facility / Birthing Center</i>	As any Admission	As any Admission
	Charges for the care and treatment of Pregnancy are covered the same as any other Illness for a covered Employee or covered Spouse. Pregnancy is not covered for Dependent Daughters. However, Prenatal Care, excluding labor, birth/delivery and post-delivery, is covered for Dependent daughters with no cost-share as required by PPACA, if billed independently. See <i>Routine Wellness / Preventive Services</i> section. See Prenatal Care under <i>Defined Terms</i> .	
Newborn Nursery – Well Child <i>Physician</i>	70%	50% after deductible

<i>Facility</i>	As any admission	As any admission
	<p>Routine well newborn nursery/Physician care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital/Physician makes a charge. Charges will be applied to the Plan of the newborn.</p> <p>This coverage is only provided if the newborn child is an eligible Dependent and is enrolled in the Plan within 30 days following its birth as specified in the section entitled "Enrollment Requirements for Newborn Children," or, if applicable, in accordance with the Special Enrollment provisions with coverage effective as of the date of birth, or, the next Open Enrollment.</p>	
Mental Health and Substance Use Disorders		
<i>Inpatient</i>	As any admission	As any admission
<i>Outpatient Facility</i>	As any outpatient facility service	As any outpatient facility service
<i>Office Visit as Primary Care</i>	\$20 copay per office visit	50% after deductible
	Psychiatrists (M.D.), psychologists (Ph.D.) or Masters of Social Work (M.S.W.) may bill the plan directly. Other licensed mental health practitioners may be asked to file claims under the direction of these professionals, depending on credentialing guidelines.	
Obesity, Morbid Obesity Non-Surgical Treatment	As any covered medical expense	As any covered medical expense
	Medically Necessary non-surgical treatment of obesity and Morbid Obesity is covered. This does not include any form of food supplement, exercise program, exercise equipment, weight control program, injection of any fluid, use of medications or educational program, if not otherwise covered.	
Obesity, Morbid Obesity Surgical Treatment	<i>No coverage provided</i>	
Orthotics	70%	50% after deductible
	Orthotics are covered for the initial purchase and fitting of an appliance designed for the support of weak or ineffective joints or muscles as a result of a disabling congenital condition or an Injury or Illness. Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.	
Private Duty Nursing	<i>No Coverage Provided</i>	
Prosthetics	70%	50% after deductible
	Benefit covers the initial purchase and fitting of a fitted artificial device to replace or augment a missing or impaired part of the body. Prosthetic devices include, but are not limited to, artificial limbs, breast prosthesis, cochlear implants and implanted lenses after cataract surgery. Repair and replacement of a device will not be made more than once every 5 years, unless it is determined Medically Necessary due to a pathological change, such as growth, shrinkage, or atrophy that results in improper fit. Replacements will not be made because the device is lost, misplaced, or stolen.	
Short-Term Therapy	70%	50% after deductible

	<p>Benefits limited to Benefit Year maximum of 30 visits combined. The Plan provides coverage for short-term rehabilitative therapy that is part of a rehabilitation program, including the therapies listed when provided in the most medically appropriate setting.</p> <p>Occupational therapy is covered when performed by a licensed occupational therapist or a Physician working within the scope of his/her license. Therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.</p> <p>Physical therapy is covered when performed by a licensed physical therapist or a Physician working within the scope of his/her license. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions that are subject to significant improvement through short-term therapy.</p> <p>Speech therapy is covered when performed by a licensed speech therapist or a Physician working within the scope of his/her license; therapy must be ordered by a Physician: a) for speech disorders; b) following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or c) to restore speech to a person who has lost existing speech function as a result of injury or an illness that is other than a learning or mental disorder.</p>	
Skilled Nursing Facility	70%	
	Benefits are payable if and when the patient is confined as a bed patient in the facility; the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and the attending Physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. Covered charges for a Plan Participant's care in these facilities are limited to the facility's semiprivate room rate.	
Sleep Studies <i>(Pre-determination required)</i>	70%	50% after deductible
	Sleep studies are covered when determined to be medically necessary. Pre-determination is required.	
Telemedicine	As any other office visit	As any other office visit
TMJ	70%	50% after deductible
	Benefit limited to Lifetime maximum of \$2,500. Includes Surgical and Non-Surgical.	
Transplant Services	<p>Transplant services are available through a separate transplant policy. See UnitedHealthcare Certificate of Coverage.</p> <p>Terms of this Summary Plan Description determine coverage of any transplant-related health services received before and after the "benefit period" defined in the <i>UnitedHealthcare Certificate of Coverage</i>.</p> <p>Also, terms of this Summary Plan Description determine coverage of any other transplant-related health services not covered by the <i>UnitedHealthcare Certificate of Coverage</i>; and all other non-transplant related health care services regardless of when received.</p>	
	In-Network	Non-Network
Vision Care		
<i>Routine Eye Exam</i>	100% up to Benefit Year maximum of \$75 / one routine exam. Annual dollar limit does not apply to essential pediatric vision care.	
<i>Frames / Lenses / Contacts</i>	No Coverage Provided	
Wig Therapy	70%	
	Following cancer treatment. Benefits limited to Lifetime maximum of one wig.	
All Other Covered Services	70%	50% after deductible

Additional Services Covered Under the Medical Benefits

Anesthetics and other certain items including administration	Certain items including anesthetics; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions are covered, including the administration thereof.
Dental Services	<p>Certain dental procedures will be Covered Charges under Medical Benefits:</p> <ul style="list-style-type: none"> • Removal of bony impacted teeth. • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. • Emergency repair due to Injury to sound natural teeth. • Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. • Excision of benign bony growths of the jaw and hard palate. • External incision and drainage of cellulitis. • Incision of sensory sinuses, salivary glands or ducts. • Reduction of dislocations and excision of temporomandibular joints (TMJs). • When Medically Necessary, replacement of teeth lost as a direct result of chemotherapy and/or radiation treatment <p>No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.</p> <p>Oral surgeons will be paid at the Network level of benefits.</p>
Family Therapy / Counseling	Family Therapy / Counseling is considered an eligible expense when provided by a licensed mental health practitioner.
Genetic Testing	<p>Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.</p> <p>Genetic testing is considered Medically Necessary (and therefore covered) based on the diagnosis, provided:</p> <ul style="list-style-type: none"> • a person has symptoms or signs of a genetically-linked inheritable disease or • the testing is performed as part of oncology treatment. <p>Genetic testing requires documentation of Medical Necessity via medical records or a letter of Medical Necessity if:</p> <ul style="list-style-type: none"> • it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome, or • the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer reviewed, evidence-based, scientific literature to directly impact treatment options as outlined in the letter of Medical Necessity noted above, or • in accordance with the guidelines and recommendations established under PPACA for preventive services for women with no cost-share. <p>If genetic testing is determined to be Medically Necessary and meets the criteria outlined above, genetic counseling may be covered. Genetic counseling is limited to 3 visits per Benefit Year.</p>
Prescription Drugs	Prescription Drugs are covered as defined in the <i>Defined Terms</i> section of this booklet. <i>Note:</i> Benefits payable for prescription drugs under Prescription Drug Benefits will not be provided under any other Plan provisions.
Reconstructive Surgery	<p>Covered Charges are:</p> <ul style="list-style-type: none"> • surgical correction of a congenital anomaly in a covered Dependent child; • treatment of an Accidental bodily Injury; and • reconstructive breast surgery following mastectomy. This mammoplasty coverage, in compliance with the <i>Women's Health and Cancer Rights Act of 1998</i>, will include reimbursement for: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a

	symmetrical appearance, and (3) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.		
Sterilization Procedures	Sterilization procedures are covered as any expense unless otherwise noted in the SPD. Reversal procedures are not covered.		
Termination of Pregnancy	Only when Medically Necessary to save the life of the mother, or in case of rape or incest, or if the fetus has a severe birth defect.		
Prescription Drug Benefits			
Prescription cost-sharing accumulates toward the Plan's overall Network Out-of-Pocket Maximum.			
	Retail Pharmacy <i>Copay covers up to a 30 day supply.</i>	Kroger Pharmacy Retail Maintenance <i>Copay covers up to a 90 day supply.</i>	Mail Order <i>Copay covers up to a 90 day supply.</i>
<i>Generic</i>	10% copay minimum \$7.50	10% copay minimum \$15	10% copay minimum \$15
<i>Preferred Brand</i>	30% copay minimum \$20	30% copay minimum \$40	30% copay minimum \$40
<i>Non-Preferred Brand</i>	40% copay minimum \$35	40% copay minimum \$70	40% copay minimum \$70
<i>Mandatory Specialty Pharmacy</i>	Same benefit as listed above under Retail Pharmacy for 30 day supply. Certain prescription drugs (including high cost injectable specialty drugs) must be purchased and dispensed by the Plan's Specialty Pharmacy program. See <i>Prescription Drug Benefits, Limitations and Exclusions</i> for more information. These drugs may not be covered by the medical benefits.		
Miscellaneous Notes			
Mandatory Generic – Except as required by PPACA, a Plan Participant will be required to pay the brand name copay plus the difference in cost between the brand name and generic if (a) he/she chooses brand name when a generic is available; or (b) when the Physician orders brand name dispensing on the prescription and a generic is available.			
Proton Pump Inhibitors - Plan will pay 100% of the cost of omeprazole and only \$20 towards the cost of all other drugs in this category.			
Statins (cholesterol lowering drugs) - All strengths of lovastatin, simvastatin, and pravastatin will adjudicate for \$4 for a 30 day supply and all other drugs in this category the plan will only pay \$25 towards the cost of the medication with the exception of Crestor 40MG, this drug will process at the current tier level.			
Triptans - Medications that fall into this category will have a quantity limit of 9 tablets per month, or 9 nasal sprays per month, or 6 injections per month.			
Flu Vaccines are covered at \$0 copay to members.			
Immunizations are covered at \$0 copay to members.			
Diabetic supplies (syringes, needles, lancets and test strips from Kroger pharmacy using Kroger brand) are covered at \$0 copay to members.			
Contraceptive management: Includes preventive services for women as required by PPACA without cost share for prescribed FDA approved contraceptives including: oral contraceptives, transdermal patches, vaginal ring, and over-the-counter products with written prescription. Also includes devices, injectables and implants. If a Generic Drug version is not available or would not be medically appropriate (as determined by your health care provider) a prescribed FDA-approved Brand Name contraceptive method will be paid by the Plan with no cost-sharing.			
Smoking Cessation: Included with prescription without cost share for Nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler and nasal spray); Sustained release Bupropion; Varenicline.			
Preventive Medications - Includes certain over-the-counter products with prescriptions without cost share as required by PPACA.			
Contact the drug card administrator listed on your ID card with questions or more information about drug availability or coverage of specialty drugs. Please visit the MedCost website at www.medcost.com for a link to more pharmacy information. See the Summary Plan Description for details of Plan provisions, definitions and exclusions.			
Please refer to remainder of Summary Plan Description (SPD) for further details on benefit provisions, definitions and exclusions.			

GENERAL PROVISIONS

A Plan Participant may contact the Plan Administrator for additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. The Plan Administrator is responsible for determining and providing Plan benefits, not the Third Party Administrator.

ELIGIBILITY

Eligibility Requirements for Employee Coverage

Eligibility Requirements for Employee Coverage

A person is eligible for Employee coverage from the first day that he or she meets the following requirements.

1. He or she is a full-time Employee of the Employer. An Employee is considered to be full-time if he or she:
 - a. has a scheduled workweek of 30 hours or more and is on the regular payroll of the Employer for that work; and/or
 - b. was deemed to be full-time during the Measurement Period, and therefore is eligible for Employee coverage during the entire Stability Period. *See also Defined Terms.*
2. He or she is in a class eligible for coverage.
3. He or she completes the employment Waiting Period of 30 days of continuous, full-time employment with the Employer. "Waiting Period" means the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

Retirees are covered to age 65 or Medicare eligible. Please refer to Human Resources for details.

Effective Date of Employee Coverage

An Employee will be covered under this Plan as of the first day of the month following 30 days waiting period provided he / she satisfies the Eligibility Requirements and the Enrollment Requirements of the Plan.*

**Note:* Waiting Period exception: If the hire date is on the 1st day of the month, the effective date will be the 1st day of the following month. For example: If hired on November 1st, the effective date will be December 1st. If hired on February 1st, the effective date will be on March 1st.

Eligible Classes of Dependents

A Dependent's coverage will be effective on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

A Dependent is any one of the following persons:

1. A covered Employee's Spouse

"Spouse" shall mean a person of the opposite gender or same gender who is legally recognized as the husband or wife under the laws of the state where the marriage took place the Employee lives. The Employer may require documentation proving a legal marital relationship.

Note: The Plan does not offer coverage to a same gender domestic partner, opposite gender domestic partner or a common-law spouse, even if the state in which the Employee lives recognizes such a partnership.

Note: Please refer to the Human Resources Department if your spouse is eligible for other employer-based coverage.

2. Children from birth to the limiting age of 26 years

Dependent children under the age of 26 are eligible for coverage without regard to student status, marital status, primary residence status, tax dependent status or the amount of financial support from the parent.

If both parents of the eligible Dependent child have employer sponsored coverage, the Dependent child may enroll in either plan. Neither plan can deny enrollment.

Coverage will end on the last day of the month during which the Dependent child's 26th birthday occurs, or in the event of the covered Employee's termination and refusal of, or loss of, COBRA continuation, whichever occurs first.

The term "children" shall include:

- Natural children.
- Adopted children, or children placed with a covered Employee in anticipation of adoption.
- Foster children.
- Step-children, as long as a natural parent remains married to the Employee and the natural parent resides in the Employee's household.
- A child for whom the covered Employee has legal guardianship and who lives with the covered Employee in a regular parent/child relationship. A parent/child relationship does not exist if either parent of the child also lives in the covered Employee's home.

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

A **Qualified Medical Child Support Order (QMCSO)** means any judgment, decree or order (including approval or settlement agreement) issued by a court of competent jurisdiction. A QMCSO is a court order that creates or recognizes the right of a covered person's child (called an alternate recipient in the law) to receive benefits under the Plan. To be considered a QMCSO, the medical child support order must clearly specify the following information:

- the name and last known mailing address of the covered person and the name and mailing address of each child covered by the order;
- a reasonable description of the type of coverage to be provided by the Plan for each such child, or the manner in which the type of coverage is to be determined;
- the period to which the order applies; and
- each plan to which the order applies.

The Plan Sponsor and Plan Administrator is responsible for establishing reasonable, written procedures for determining if the court order is a QMCSO. The Plan Sponsor and Plan Administrator must notify the Covered Person and the child that a court order has been received and within a reasonable time inform the Covered Person and the child whether or not the court order is a QMCSO. If the court order is determined to be a QMCSO, the child is an alternate recipient and considered a beneficiary under the Plan. Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the child, the child's custodial parent or other designated representative, or if benefits are assigned, to the provider of care.

The court order may not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan. If a state has paid for medical services for the child under Medicaid for which the Plan was liable, the state may seek to recover those amounts paid from the Plan.

3. A covered Dependent child is mentally or physically handicapped

If a covered Dependent child is mentally or physically handicapped before reaching the limiting age for an eligible Dependent, his or her coverage will be continued if it would otherwise end due to attainment of the limiting age.

The child's coverage will be continued after reaching the limiting age as long as: (a) he or she remains handicapped; (b) he or she remains unmarried and chiefly dependent on the covered Employee for support; (c) the covered Employee remains covered under the Plan; (d) the part of the Plan providing his or her coverage remains in force; and (e) the covered Employee continues to pay any part of the cost required for the child's coverage.

The covered Employee must provide proof of the child's handicap and dependence within 30 days of the date the child would otherwise no longer qualify as an eligible Dependent. The Plan will require proof of the child's continuing handicap and dependence. Proof may be required every two years. Coverage for the child will end immediately if the proof is not satisfactory.

Eligibility Requirements for Dependent Coverage

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

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

These persons are excluded as Dependents:

- Other individuals living in the covered Employee's home, but who are not eligible as defined.
- The legally separated Spouse of the Employee under the laws of the state where the covered Employee lives.
- The divorced former Spouse of the covered Employee.
- Any person who is on active duty in any military service of any country.
- Any person who is covered under the Plan as an Employee.

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

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

FUNDING

Cost of the Plan: Botetourt County shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

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.

Employees contribute toward the cost of all coverage under the Plan through payroll deductions. Premium contributions for health coverage are allowed on a pre-tax basis in conjunction with a Section 125 plan offered by the Employer. Section 125 plan elections are binding for one year unless a recognized change occurs. Refer to the Enrollment Section of this Summary Plan Description for a listing of the situations that permit an election change, or contact the Employer's Human Resources Department for additional information.

ENROLLMENT

Enrollment Requirements

If coverage is desired, an Employee must enroll for coverage by filling out and signing an enrollment application. If the Employee wants coverage for his/her Dependent(s), he/she is required to enroll for Dependent coverage, also. The completed enrollment form must be received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Enrollment Requirements for Newborn Children

A newborn child of a Covered Employee is not automatically enrolled in this Plan. For coverage to begin at birth, the child must be enrolled in the Plan within 30 days following its birth. This means an enrollment form on behalf of the newborn is required to be completed to ensure accurate information and timely claims payments, and must be received by Human Resources within 30 days following the birth of the child. If the newborn child is not enrolled in this Plan within 30 days following its birth, there will be no payment from the Plan for expenses of the newborn and the covered Employee will be responsible for all expenses of the newborn. Such a newborn child will be permitted to be enrolled in the Plan in accordance with the Special Enrollment provisions with coverage effective as of the date of birth, or, the next Open Enrollment.

See Newborn Nursery for Plan provisions with respect to Hospital/Physician charges for routine nursery and Physician care and other normal care for which a Hospital/Physician makes a charge. This provision will state whether such charges are considered charges of the mother or charges of the newborn child.

Special Enrollment Rights

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including his spouse) because of other health insurance or group health

plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Plan will give Employees and/or Dependents who are eligible but not enrolled for coverage under the Plan the opportunity to enroll when the Employee's or Dependent's Medicaid or State Children's Health Insurance Program (SCHIP) coverage terminates as a result of loss of eligibility. Coverage under this Plan must be requested within 60 days after the loss of Medicaid or SCHIP.

The Plan will give Employees and/or Dependents who are eligible but not enrolled for coverage under the Plan the opportunity to enroll when the Employee and/or Dependent is determined to be eligible for premium assistance under Medicaid or the Children's Health Insurance Program (CHIP). Coverage under this Plan must be requested within 60 days of being determined to be eligible for the premium assistance.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more information, contact the Plan Administrator, Botetourt County, 5 West Main Street, Suite 200, Fincastle, VA 24090; (540) 473-8349.

Special Enrollment Periods

Special enrollment periods are allowed due to certain losses of other coverage and changes in family status. A special enrollment period is allowed due to loss of other coverage if you:

- declined coverage when you first became eligible for it;
- stated in writing that coverage was declined due to the existence of other coverage;
- have now lost the other coverage; and
- request enrollment within 30 days after losing the other coverage (other than Medicaid or SCHIP); or
- request enrollment within 60 days after losing eligibility for Medicaid or SCHIP.

A special enrollment period is allowed due to a change in family status if you are an eligible Employee who has gained a Dependent through marriage, birth, adoption, or placement for adoption. In this situation, the special enrollment period is allowed for you and your eligible Dependents. The special enrollment period will be 30 days beginning on the date you gain at least one eligible Dependent for one of the reasons listed.

"Other coverage" for the purposes of determining if a special enrollment period will be allowed is defined as:

- group health coverage which ended because the employer ceased paying the contribution for it; or
- group health coverage that ended due to a loss of eligibility caused by legal separation, divorce, death, termination of employment, or reduction in work hours; or COBRA continuation coverage that has been exhausted.

For persons enrolled during a special enrollment period due to a change in family status, coverage will begin:

- on the date of marriage, if the special enrollment period is due to marriage;
- on the new Dependent's date of birth, if the special enrollment period is due to the birth of a child;
- on the date the new Dependent is adopted or placed for adoption if the special enrollment period is due to adoption or placement for adoption.

A special enrollment period is allowed due to a court or administrative order if the order requires a parent to provide health benefit plan coverage for a child, and the parent is eligible for Dependent coverage under the Plan.

If the eligible parent fails to enroll the child, he or she may be enrolled by the other parent, the Plan Administrator or a state child support enforcement agency of the state in which the child resides. Dependent coverage for the child will begin on the date he or she is enrolled under the terms of the order; or on the date specified in the order, if later.

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

Change in Family Status

The Plan permits Plan Participants to change his/her benefit election during the Benefit Year if a qualified change in family status occurs and this change affects his/her eligibility to participate in the Plan. MedCost Benefit Services *Change Forms* are available from the Human Resources Department or at www.medcost.com. A qualified change in family status may occur for many reasons such as those listed below.

The Employee must notify the Plan Administrator, in writing, within 30 days of a change in status and comply with all other Plan provisions and requirements. Modified elections are generally effective the 1st of the month following receipt and approval by the Plan Administrator (with the exception of the birth of a newborn, adoption or placement for adoption of a Dependent child whose elections will become effective retroactive to the event date).

- **Birth or Adoption:** A Change Form should be completed indicating the name of your new Dependent child and the date of birth/adoption.
- **Marriage:** A Change Form should be completed indicating the name of your new Spouse and date of your marriage.
- **Divorce:** Complete a Change Form indicating the date of the divorce or separation. Because it is against COBRA laws to terminate a Spouse's or Dependent's health coverage in anticipation of a divorce or separation, attach a copy of the divorce decree or legal separation document.
- **Dependent child ceases to be a Dependent as defined by the Plan:** Complete a Change Form indicating the termination date of coverage for the child. (This form is required even if the child is, or might, continue coverage under COBRA.)
- **Termination of Employment:** (See *Termination of Employee Coverage* on a following page.) Complete a Change Form indicating a termination date of coverage. (This form is required even if you are, or might, continue coverage under COBRA.)
- **Spouse's loss of health coverage** due to loss of his/her employment, your Spouse's employer no longer offers a health plan or your Spouse's employer not offers health coverage to the class of employees that includes your Spouse: See *Special Enrollment Rights* and *Special Enrollment Periods* on a preceding page.
- **Judgment, Decree or Order:** If the Employee or Employee's Spouse is subject to a judgment, decree or order resulting from a divorce or similar proceeding that affects the requirements for the Employee to provide medical coverage for a Dependent child, a Change Form should be completed adding the Dependent child accordingly.
- **Family and Medical Leave Act:** If the Employee takes leave under the Family and Medical Leave Act (FMLA), he/she can elect to continue group health coverage as provided by FMLA or he/she may revoke coverage while on leave.
- **Significant Cost Increases:** If the cost of benefits significantly increases during the Benefit Year, the Employee may elect coverage under another benefit option, if any, which offers similar coverage. The employer will determine if the increases are significant enough to allow a change.
- **Coverage Changes:** If coverage under a benefit option is significantly curtailed during a Benefit Year, the Employee may revoke his/her election, or elect another benefit option, if any, which offers similar coverage. If the employer adds a new benefit option during a Benefit Year, the Employee may elect the new benefit option.
- **Changes Under Another Employer's Plan:** The Employee may also change his/her elections to correspond with certain changes that the Employee's Spouse makes to his or her benefit elections under a benefit plan offered by the Spouse's employer. These rights are subject to conditions or restrictions that may be imposed by the Spouse's employer or any insurance company providing benefits under the Spouse's Plan.

Open Enrollment

During the Plan's annual Open Enrollment period, covered Employees will be able to change some of their benefit decisions based on which benefits and coverages are right for them and their Dependents, if any.

During the Plan's annual Open Enrollment period, an Employee will be able to enroll in the Plan. In no event will any Employee be allowed to enroll for coverage under the Plan during the Open Enrollment period unless he or she has completed all of the Eligibility Requirements as set out on a previous page.

Benefit choices made during the Open Enrollment period will become effective December 1st and remain in effect and are binding until the next following unless a person experiences an event that qualified as a Special Enrollment event under the Eligibility provisions of the Plan. See Human Resources for additional information. A Plan Participant who fails to make an election during Open Enrollment will automatically retain his or her present coverages. Plan Participants will receive detailed information regarding Open Enrollment from the Plan Sponsor.

TERMINATION OF COVERAGE

Termination of Employee Coverage

Employee coverage will end automatically upon the earliest of the following dates. In certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section *Coverage Continuation Rights Under COBRA*.

- The date the Plan is terminated.
- The end of the month during which the covered Employee ceases to be eligible for coverage under this Plan.
- The end of the month that the covered Employee retires or dies.
- The end of the month during which the covered Employee fails to make any required contribution for coverage.

Employer-Approved, Non-FMLA Leave of Absence / Layoff

While on leave without pay, the Eligible Employee may continue his / her health coverage, if leave continues beyond one pay period, by payment of the Employee and County shares of the premium. During a layoff, his / her health coverage ends the last day of the month during which the Employee was actively at work.

While continued, coverage will be that which was in force on the last day worked as an Eligible Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. The Plan reserves the right to choose a different plan for continuing coverage; however, any such plan will not be discriminatory.

Continuation during Family and Medical Leave (FMLA)

Regardless of the established leave policies mentioned above, if the Employer is subject to FMLA regulations, this Plan shall at all times comply with the *Family and Medical Leave Act of 1993* as promulgated in regulations issued by the Department of Labor.

The following is a brief description of the main provisions of the *Family and Medical Leave Act of 1993*. It does not detail every provision of the Act. Employees should contact their Human Resources Department or the Plan Administrator for additional information or a copy of the Employer's written policy regarding compliance with the *Family and Medical Leave Act*.

The Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 12 weeks during a qualified leave of absence, which includes any of the following:

- The birth of a child, or placement of a child for adoption or foster care;
- To care for a spouse, child, or parent with a serious health condition;
- As a medical leave when the Employee is unable to work due to a serious medical condition; or
- Any qualifying exigency (i.e., emergency or necessity) arising out of the fact that the Employee's spouse, son, daughter or parent is a military member on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation.

Additionally, the Act provides that a covered Employee may continue his or her coverage under the Plan for a maximum of 26 weeks in a single 12-month period during a leave of absence to care for a service member with a serious injury or illness incurred in the line of duty. The covered Employee must be a spouse, son, daughter, parent or next of kin of the injured or ill service member.

To be eligible, the covered Employee must have been employed with the Employer for at least 12 months, must have worked at least 1250 hours during the 12 months preceding the leave, and must be employed at a worksite where 50 or more employees are employed within 75 miles of that worksite*. The 12 months an Employee must have been employed do not have to be consecutive. Whether an Employee has worked at least 1250 hours during the preceding 12 months must be determined as of the date the leave is to begin.

(Employees who are exempt from the *Fair Labor Standards Acts*' minimum wage and overtime requirements, and who have been employed for at least 12 months are presumed to have met their 1250-hour eligibility.)

During an FMLA qualified leave of absence, the Employee's benefits under the Plan may continue as if he or she was actively at work. The Employee must continue to pay any part of the cost he or she was required to pay before the leave began.

*Note: The Employer makes the determination as to whether the Employer is subject to FMLA regulations, and whether or not the Employee meets the eligibility requirements for leave under FMLA. Employees should contact their Human Resources Department with questions related to FMLA.

Employees on Military Leave (USERRA)

1. In any case in which an Employee has coverage under the Plan, and such Employee is absent from such position of employment by reason of service in the uniformed services, the Employee may elect to continue coverage under the Plan as provided in this section. The maximum period of coverage of the Employee and the Employee's Dependents under such an election shall be the lesser of:
 - a. The 24 month period beginning on the date on which the Employee's absence begins; or
 - b. The day after the date on which the Employee fails to apply for or return to a position of employment, as determined under the *Uniformed Services Employment and Re-Employment Rights Act (USERRA)*.
2. An Employee who elects to continue Plan coverage under this section must pay 102% of his or her normal premium under the Plan. Except that, in the case of an Employee who performs service in the uniformed services for less than 30 days, such Employee will pay his or her normal contribution for the 30 days.
3. An Employee who is qualified for re-employment under the provisions of USERRA will be eligible for reinstatement of coverage under the Plan upon re-employment. Except as provided in paragraph #4 below, upon re-employment and reinstatement of coverage no new exclusion or waiting period will be imposed in connection with the reinstatement of such coverage if an exclusion or waiting period would normally have been imposed. This paragraph applies to the Employee who is re-employed and to an individual who is covered by the Plan by reason of the reinstatement of the coverage of such Employee.
4. Paragraph #3 shall not apply to the coverage of any illness or injury determined by the Secretary of Veteran's Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.

Rehiring a Terminated Employee

A previously covered Employee who terminates coverage and whose eligibility is reinstated within 13 weeks of his or her termination date will not be required to satisfy the Employer's Waiting Period, if any. All other previously covered Employees who are reinstated will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. An Employee returning to work directly from COBRA coverage will not have to satisfy the employer's waiting period, if any. Refer to the Human Resources Department regarding any questions about rehire provisions.

Termination of Dependent Coverage

Dependent coverage will end automatically upon the earliest of the following dates. In certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. See the section *Coverage Continuation Rights Under COBRA*.

- The date the Plan is terminated; or
- The end of the month during which the Employee's coverage under the Plan terminates for any reason including death.
- The end of the month during which a covered Spouse loses coverage due to loss of dependency status.
- The end of the month during which a Dependent child ceases to be a Dependent as defined by the Plan.
- The end of the month during which the required contribution has been paid if the charge for the next period is not paid when due.
- With respect to a child required to be covered under the terms of a court or administrative order, the earlier of the date the order is no longer in effect, or the date the child becomes covered under another comparable plan of health benefits.

Rescission of Coverage

It is the Employee's responsibility to notify the Plan of any change in the eligibility status of himself/herself or a Dependent. Coverage for Dependent children ends when a Dependent child reaches the limiting age as specified in this document. The Employee must notify the Plan of a divorce so that the Employee's Spouse may elect other coverage outside of this Plan or through a COBRA offering, if applicable.

Fraud and misrepresentation of a material fact by Employees or Covered Persons are prohibited. The Plan reserves the right to rescind coverage if a Covered Person performs an act, practice or omission that constitutes Fraud or makes a misrepresentation of a material fact relating to health care or coverage. Upon discovery of such Fraud or misrepresentation of material fact, thirty (30) days advance written notice will be provided to the person for whom coverage is being rescinded. Notice to the person is sufficient when addressed to such person at his/her

address as it appears in the Plan's records. An Employee has the right to appeal a Rescission of coverage. See also Claims Procedures and Appeals, and Defined Terms.

Rescission of coverage may result in the reversal and/or denial of claims. The Plan may also seek to recover UCR charges for services provided following the date of Rescission. See UCR under Coverage of Medical Expenses.

HEALTH MANAGEMENT SERVICES
>>> Provided by MedCost Health Management <<<

The patient or family member or attending Physician must call (800) 795-1023 to receive precertification for the Health Management Services described below. **If precertification is not received, eligible expenses may be reduced.**

>>> PRECERTIFICATION IS NOT A GUARANTEE OF COVERAGE OR PAYMENT <<<

MedCost Health Management is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under this Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

The Health Management Services include:

- Utilization Review
 - Precertification
 - Concurrent Review
 - Discharge Planning
- Outpatient Review
- Catastrophic Case Management

UTILIZATION REVIEW

Utilization Review is a set of formal methods designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers or facilities. All Medical benefits are subject to Utilization Review.

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

PRECERTIFICATION

The following services must be precertified before medical and/or surgical services are provided:

- Hospital Admissions
- Hospital Observation Unit stays of more than 48 hours
- Certain diagnostic services rendered as Outpatient or in Physician's office – See *Outpatient Review*
- Dialysis Services

Maternity Note: 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. Under Federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Precertification for non-emergency admissions should be requested **at least 48 hours** before the service is provided. You should call MedCost Health Management at (800) 795-1023 with the following information:

- The name of the patient and relationship to the covered Employee;
- The name, patient identification number and address of the covered Employee;
- The name and group number of the Employer;
- The name of the Medical Care Facility and proposed date of the procedure;
- The name and telephone number of the attending Physician;
- The diagnosis and/or type of service to be provided.

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 MedCost Health Management **within 72 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of confinement or use of other listed medical services appropriate for care. ***Failure to follow this procedure may reduce reimbursement received from the Plan.***

If the Plan Participant does not receive precertification, Room and Board charges for non-precertified days will be denied by the Plan.

In addition, for a Hospital confinement for which precertification is requested but has been determined to not be Medically Necessary, room and board will not be payable. Expenses for other covered services provided during the Hospital confinement (including X-ray and laboratory services, etc.) will be considered in accordance with applicable Plan provisions.

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

CONCURRENT REVIEW

After admission to the Medical Care facility, the utilization review administrator will monitor the Plan Participant's Medical Care Facility stay or use of other medical services, and coordinate with the attending Physician, Medical Care Facilities and Plan Participant.

DISCHARGE PLANNING

If the attending Physician feels that it is Medically Necessary for a Plan 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.

If the Plan Participant does not receive precertification for additional inpatient days, Room and Board charges for non-precertified days will be denied by the Plan.

In addition, for a Hospital confinement for which precertification is requested but has been determined to not be Medically Necessary, room and board will not be payable. Expenses for other covered services provided during the Hospital confinement (including X-ray and laboratory services, etc.) will be considered in accordance with applicable Plan provisions.

Please remember that precertification does not guarantee coverage or payment. Contact MedCost Benefit Services Customer Service at (800) 795-1023 to verify your eligibility and benefits.

OUTPATIENT REVIEW

Outpatient Review concentrates on services that are costly or highly utilized. *Precertification is **required** for the following diagnostic procedures:

- **CT scan** performed as an Outpatient or in a Physician's office
- **MRI** performed as an Outpatient or in a Physician's office
- **PET** scan performed as an Outpatient or in a Physician's office

***Services performed in emergent situations (to rule out need for surgery or urgent treatment) are not subject to the requirement for Outpatient Review / Precertification.**

Precertification for these services should be requested **at least 48 hours** before the service is provided. You should call MedCost Health Management at (800) 795-1023 with the following information:

- The name of the patient and relationship to the covered Employee
- The name, patient identification number and address of the covered Employee
- The name and address of the covered Employee
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of service to be provided
- The proposed rendering of listed medical services

If the Plan Participant does not receive precertification for these services, expenses will be denied due to lack of Medical Necessity.

Please remember that precertification does not guarantee coverage or payment. Contact MedCost Benefit Services Customer Service at (800) 795-1023 to verify your eligibility and benefits.

CATASTROPHIC CASE MANAGEMENT

When a catastrophic condition such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term care. After the person's condition is diagnosed, he or she might need extensive services, or might be able to be moved into another type of care setting – even to his or her home.

Case Management is utilization review for services and supplies needed by a patient with a serious, complicated, or protracted health condition. It may include discharge planning, which is done to coordinate and manage the care a patient receives after discharge from a Hospital or Skilled Nursing Facility. The goal of Case Management is to identify safe, effective treatment alternatives in lieu of more costly ones.

Sometimes, treatment that may not otherwise be covered by the Plan may be recommended as 'alternative treatment'. The Plan will provide benefits for alternative treatment that is approved and agreed upon by the Plan, the Covered Person and the Covered Person's doctor, if it is determined that such alternative treatment is medically necessary and cost effective. An example of alternative treatment is Home Health Care or Skilled Nursing beyond Plan limits. Providing benefits for alternative treatment in one situation does not require the Plan to provide similar benefits in another. This provision is not a waiver of the Plan's right to administer the Plan in strict accordance with its terms.

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

- personal support to the patient
- contacting the family to offer assistance and support
- monitoring Hospital, Rehabilitation or Skilled Nursing facility confinements;
- determining alternative care options; and,
- assisting in obtaining any necessary equipment and services.

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

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

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.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties, except and related services as well as dialysis treatment, if the patient and family choose not to participate. *See separate policy for transplant services.*

COVERAGE OF MEDICAL EXPENSES

Network Provider Plan

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Therefore, when a Plan Participant uses a Network Provider, he/she will receive a higher payment from the Plan than when a Non-Network Provider is used. It is the Plan Participant's choice as to which Provider to use.

Under the following circumstances, the Network payment will be made for certain Non-Network services:

- If a Plan Participant has no choice of Network Providers in the specialty that the Plan Participant is seeking within the Network service area.
- If a Plan Participant is out of the Network service area and has a Medical Emergency requiring immediate care.
- If a Plan Participant receives the services of a Non-Network Provider in a Network facility, when the Plan Participant is not given the opportunity to specify or request the services of a Network Provider.
- If a Plan Participant receives Non-Network services and the provider has accepted a negotiated discount arranged either through MedCost or through a third party contracted by MedCost and/or MedCost Benefit Services.

Deductibles/Copays

A deductible is an amount of money that is paid once a Benefit Year per Plan Participant. Typically, there is one deductible amount per Plan Participant and it must be paid before any money is paid by the Plan for any Covered Charges that are subject to the deductible. Each December 1st, a new deductible amount is required. Deductibles do accumulate toward the 100% maximum Out-of-Pocket payment.

A Copay is a fixed amount of money that is paid each time a particular service is used. Typically, there may be copays on some services and other services will not have any copays. Copays accumulate toward the 100% maximum Out-of-Pocket payment.

Charges applied toward the Network deductible are separate and distinct from the Non-Network deductible.

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

This Plan includes a provision that applies when two or more Plan Participants in a Family Unit are injured in the same Accident. These persons need not meet separate deductibles for treatment of injuries incurred in this Accident; instead, only one deductible for the Benefit Year in which the Accident occurred will be required for them as a unit for expenses arising from the Accident.

Out-of-Pocket Maximums

A combination of the Network and Non-Network Out-of-Pocket amounts will never exceed the Non-Network Out-of-Pocket amount.

No more than the amount(s) stated in the Schedule of Benefits needs to be paid for allowable expenses during a Benefit Year. This amount caps the Plan Participant's coinsurance percentage (for example, 20%). For the rest of that year the Plan will pay 100% of certain allowable expenses exceeding the outlined amount.

Charges for health management penalties do not apply to the Out-of-Pocket Maximums per Benefit Year.

COVERED MEDICAL EXPENSE

The term Covered Medical Expense means an expense incurred for Covered Charges, but only if the expense is incurred while you and / or your Dependent(s) are covered by this Plan, and only to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary care and treatment of an Injury or Illness.

Covered Medical Expense includes expenses filed in accordance with coding guidelines as defined by the current Uniform Billing Code, Centers for Medicare and Medicaid, ICD-9 (or its successors), and CPT-4. This includes coding according to the American Medical Association's (AMA's) guidelines that state the code(s) reported / billed "accurately identifies the service performed." The term Covered Medical Expense also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-9 (or its successors), CPT-4, and HCPCS codes with their appropriate modifiers for adjudication. Inclusion or exclusion of a procedure in, or from, one of the aforementioned sets of coding guidelines does not imply any coverage or entitlement to reimbursement.

Covered Medical Expense includes professional fees incurred when a professional service has specifically been provided to a Covered Person. A claim filed for a professional fee for a computer generated report is not a Covered Medical Expense.

The term Covered Medical Expense does not include charges billed according to inappropriate billing practices, including, but not limited to, billing for undocumented services, billing for services not rendered, unbundling, up-coding or balance billing. Such services should not be billed to the patient. Charges that are not coded in compliance with industry standards will not be deemed Covered Medical Expenses.

All charges are subject to Usual, Customary and Reasonable (UCR) determination. To determine UCR, the Claims Administrator shall consider the following factors:

- the provider's "Usual" charges comprised of the fees that an individual provider most frequently charges for a specific type of treatment or service; and
- the "Customary" charges, based on one or more of the following:
 - statistically credible health care services data (updated no less than quarterly); or
 - a Preferred Provider (PPO) fee schedule; or
 - Medicare-based reimbursement; and
- the "Reasonable" charges, based on consideration of:
 - charges based on a negotiated discount arrangement with the provider at issue for the charges in question; or
- for Non-Network charges, each of the following:
 - the complexity or severity of the treatment or service at issue; and
 - the level of skill and experience involved in delivery of the treatment or service; and
 - the value of the treatment or service compared to other treatments or services.

Charges that are not coded in compliance with industry standards are presumed to be unreasonable.

Charges will be considered in excess of UCR if they exceed any of these three factors (Usual, Customary and Reasonable). Charges in excess of UCR will not be considered Covered Medical Expenses. When charges are in excess of UCR, you may incur costs associated with charges that exceed Usual, Customary and Reasonable charges.

MEDICAL BENEFIT EXCLUSIONS

Charges for the following *are not covered*:

Acupuncture; acupressure, hypnotherapy, biofeedback.

Administrative costs for completing claim forms or reports; for providing medical records requested by the Plan; postage, shipping and handling charges; interest or financing charges; telephone calls, conferences; consultations. This exclusion does not apply to the Telemedicine benefit.

Ambulance services Ambulance services for non-emergency travel, including but not limited to, home to routine Outpatient medical treatment, Physician visits, physical therapy or chemotherapy, or travel that is not Medically Necessary.

Appointments. Charges for broken or missed appointments.

Purchase of **breastfeeding equipment** from a retail store.

Chelation therapy except as Medically Necessary for the treatment of heavy metal poisoning.

Claims submitted more than twelve (12) months after the date of service.

Complications arising from non-covered services or treatment. No benefits are payable for any care, treatment, services or supplies, whether or not prescribed by a Physician, or charges incurred as a result of complications arising from a service or procedure that is not a covered medical expense.

Cosmetic surgery (elective) or other services and supplies that improve, alter or enhance appearance, whether or not for psychological reasons. (See *Additional Benefits, Reconstructive Surgery.*)

Custodial care. Services and supplies, including confinement, that are provided to an individual primarily to assist with his/her daily living activities. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing oneself, dressing oneself, eating and taking medications. This Exclusion does not apply to a formal Hospice care program.

The Plan will not pay for Hospital care, nursing home or Skilled Nursing facility care, home care, or a school or other institution for behavior and/or developmental modification or care, or any other service that is custodial in nature.

Dental care. The Plan does not pay for dental treatment, including orthodontia, except as specifically provided under *Additional Benefits*.

Dependent pregnancy. The Plan excludes charges for pregnancy including delivery and complications for covered dependents other than the Covered Spouse of the Covered Employee.

Educational or vocational testing. Services for educational or vocational testing or training. This Exclusion does not apply to diabetic self-management programs for training for the use of diabetic supplies. *See also Learning Disorders.*

Excess charges. The part of an expense for care and treatment of an Injury or Illness that is not a Covered Medical Expense.

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

Experimental, Investigational or not Medically Necessary. Experimental or Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently or at the time the charges were incurred recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed.

This Exclusion may not apply to Qualified Clinical Trial services (see *Defined Terms*).

This Exclusion may not apply when a patient is receiving treatment that follows published protocol of a Qualified Clinical Trial and has satisfied the patient selection criteria, although the patient is not enrolled in the Qualified Clinical Trial. To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis.*

This Exclusion may not apply when a patient has been diagnosed with cancer for which there is not an established treatment protocol (Standard of Care). To be considered a covered expense by the Plan, the treatment must be supported by clinical evidence with reasonable expectation that the treatment will improve the patient's medical condition and prognosis. *

**For the purposes of determining if the "Experimental, Investigational or not Medically Necessary" exclusion shall not apply due to the clinical evidence providing a reasonable expectation that the treatment will improve the patient's medical condition and prognosis, such reasonable expectation shall be determined solely by the Plan. The Plan reserves the right to utilize resources qualified to assist in such determinations as warranted.*

This exclusion may not apply to a drug which has been approved by the Federal Food and Drug Administration (FDA) for a specific medical condition, but which is sought to be provided for another medical condition. This is referred to as "off-label use". To be considered a covered expense by the Plan, off-label drugs being prescribed must have been:

1. Approved by the FDA for commercial distribution, and
2. Supported in reputable medical compendia* as effective and accepted treatment for the off-label condition.

**Reputable Medical Compendia includes, but is not limited to:*

Accc-cancer.org	Cancer.gov
Chemoregimen.org	Compendia
FDA.gov	Medscape.com
Medlineplus.gov	NCCN.org
NIH.gov	U.S. Pharmacopoeia

Eye care. Glasses or lenses or their fitting; eye surgery to correct nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea. This Exclusion does not apply to aphakic patients and soft lenses, sclera shells intended for use as corneal bandages or vision benefits specifically stated in the *Schedule of Benefits*.

Foot care. Charges resulting from weak, unstable or flat feet; bunions; routine foot care including corn and callus treatment or removal; or nail trimming, unless necessary for diabetic foot care. This exclusion does not apply to surgery for the above listed conditions.

Orthopedic foot appliances, including custom molded foot orthotics, may be covered when used as an integral part of a brace, applied tightly thereto, or when used to treat a condition requiring more than a supportive device of the foot. Shoe inserts are not considered orthotic devices by this Plan and are not covered.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.

Genetic testing and counseling, except as noted in the *Schedule of Benefits* section of this document. Genetic testing for the purposes of determining the paternity of a child or the sex of a child is not covered.

Government coverage. Confinement, treatment or services that are paid for or furnished by the United States Government or one of its agencies. This does not apply to Medicaid or when otherwise prohibited by law.

Growth hormones unless Medically Necessary. See *Prescription Drug Benefits, Limitations & Exclusions, and/or Specialty Pharmacy*.

Hair loss, including wigs, toupees, hair transplants, hair prostheses, hair weaving, or any drug that promises hair growth, whether or not prescribed by a Physician. This Exclusion does not apply to wigs purchased following cancer treatment.

Hearing aids. Charges for services or supplies in connection with hearing aids or exams for their fitting unless

- required due to Accidental Injury; or
- hearing loss is a result of a surgical procedure.

This exclusion does not apply to pediatric screening.

Holistic or homeopathic medicine.

Hospital employees. The Plan will not pay for services billed directly by any person (Physician, nurse, therapist, etc.) who is an employee of a Medical Care facility and whose services are paid by the Medical Care facility.

Illegal Acts. Charges for services rendered as a result of an injury or illness which was caused by one of the following:

- The use of illegal narcotics or non-prescribed controlled substances (unless administered on the advice of a physician); or
- Being illegally intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place), while operating a motorized vehicle; or
- Engaging in a riot or public disturbance, aggravated assault, illegal occupation, or felony; or
- A Serious Illegal Act. A "Serious Illegal Act" is any act or series of acts for which a sentence to a term of imprisonment in excess of one year could be imposed (regardless of the individual's own criminal history) if the act were prosecuted as a criminal offense in the state where the act took place.

In each instance, it is not necessary that criminal charges be filed or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required. This exclusion does not apply to the victims of such acts. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a covered medical condition (including both physical and mental health).

Immunizations and/or Vaccines needed for travel not required by the Employer.

Impotence. Care, treatment, services, supplies or medications in connection with impotence.

Infertility. The Plan does not cover reversal of voluntary sterilization; medical services (surgical or therapeutic) to correct the cause of the infertility; gamete intra-fallopian transfer (GIFT); zygote intra-fallopian transfer (ZIFT); in vitro fertilization (IVF); donation, preservation, preparation, analysis and storage of sperm, eggs or embryos; drug treatments for stimulating ovulation; any costs related to surrogate parenting; infertility services required because of a sex change by a Plan Participant or covered Spouse; or any assisted reproductive technology or related treatment. Also, the Plan will not cover any costs for Infertility diagnosis or treatment if the covered Employee or covered Spouse has had a prior sterilization procedure or if infertility is the result of a normal physiological change such as menopause.

Learning Disorders/Developmental Testing. Services, treatment and diagnostic testing related to learning and/or developmental disorders unless it is medical treatment for a diagnosed medical condition, and not only for behaviors associated with that diagnosis. *See also Educational or Vocational Testing.*

Marital or pre-marital counseling.

Never Events – treatment or services for unintended injury or illness resulting from an adverse consequence of care that could reasonably have been prevented, including but not limited to: foreign object left in body after surgery, surgery performed on wrong body part, air embolism, blood incompatibility, etc. For more information see http://www.cms.gov/HospitalAcqCond/06_Hospital-Acquired_Conditions.asp#TopOfPage.

No charge. Confinement, treatment or services for which the Plan Participant has no financial liability or that would be provided at no charge in the absence of insurance coverage.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Confinement, care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the Injury or Illness.

Further, charges will not be paid for services, supplies or treatment not commonly and customarily recognized throughout the Physician's profession, or by the American Medical Association (AMA) as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the AMA as having no medical value.

Non-Emergency Hospital Admissions. Any admission and related inpatient Hospital charges incurred on a Friday, Saturday, or Sunday unless the admission is necessary due to an emergency or if surgery is performed within 24 hours of the admission, unless the admission is pre-certified for medical necessity.

Not specified as covered. Non-Traditional Medical Services, treatments and supplies which are not specified as covered under this Plan. See *Defined Terms*.

Obesity. Surgical treatment of obesity, Morbid Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Also excluded are vitamins, diet supplements, special diets, recreational therapy, education therapy, self-help training or enrollment in a health, athletic or similar club. This exclusion does not apply to any preventive vitamins or supplements that may be required by PPACA. Pediatric obesity screenings are covered under Routine Wellness.

Occupational. No benefits will be provided for losses which result from an Illness or Injury:

- that arises out of or in the course of employment (including self-employment) with any employer who is eligible to obtain coverage under Workers' Compensation, or occupational disease law;
- for which the Plan Participant is eligible for benefits under any Workers' Compensation law or occupational disease law; or
- for which the Plan Participant is paid a Workers' Compensation benefit or occupational disease law benefit.

Personal Comfort Items. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in conjunction with custodial care, educational or training or expenses actually incurred by other persons except as specifically addressed elsewhere in this document. Personal comfort items include, but are not limited to: air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first aid supplies and non-hospital adjustable beds.

Plan design excludes. Charges excluded by the Plan design as described in this document.

Pregnancy of daughter. Care and treatment of Pregnancy for a dependent daughter, except for Prenatal Care as required by PPACA. Complications of Pregnancy are not covered. See Prenatal Care under *Defined Terms*.

Prescription drugs. Benefits payable with the prescription drug card will not be provided under the medical benefit provisions.

Psychological or psychiatric counseling incurred as a result of or in connection with behavior, conduct and/or behavioral disorders, including but not limited to truancy, delinquency, tantrums or stealing where there is no underlying mental or emotional disorder.

Reimbursement. Treatment received or expenses incurred by a Plan Participant that are reimbursed, entitled to reimbursement, or are in any way indemnified by or through any public program except when this Plan is required by Federal Law to pay as primary.

Relative giving services. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

Residential Treatment. Residential treatment for Mental Health and Substance Use Disorders is not covered for the following:

- The use of foster homes or halfway houses.
- For wilderness center training.
- For therapeutic boarding schools.
- For custodial care, situation or environmental change.

Room and Board for Partial Hospitalization. Charges billed for Room and Board in connection with any Partial Hospitalization services are excluded.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ended under this Plan.

Sex Change / Sexual Dysfunctions. Charges for services due to sexual dysfunctions, sex transformation, non-congenital transsexualism, gender dysphoria or sexual reassignment or sex change are excluded. This Exclusion includes, but is not limited to, medications, implants, hormone therapy, surgery, medical or psychiatric treatment, sex therapy programs or psychotherapy for problems related to sexual dysfunction or sex change.

Subrogation. Claims directly related to or arising out of an Injury or Illness for which the Plan Participant has, or may have, any claim or right to recovery, when the completed and signed acknowledgement form (as described in the *Reimbursement and or Subrogation* section) is not delivered to the Claims Administrator within 12 months of the date that such form is first sent by the Claims Administrator to the Plan Participant.

Surgical sterilization reversal.

Termination of Pregnancy other than when Medically Necessary to save the life of the mother, or in case of rape or incest, or if the fetus has a severe birth defect.

Transplants. The Botetourt County Employee Benefit Plan has a separate policy for Transplants and excludes any expenses for which benefits are payable under the *UnitedHealthcare Certificate of Coverage*.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except as *specifically* stated in this *Summary Plan Description*, or for travel that is not Medically Necessary.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or for service related charges incurred while serving in the armed forces of any country.

PREScription DRUG CARD BENEFITS, LIMITATIONS AND EXCLUSIONS

Participating pharmacies have contracted with the Plan to charge Plan Participants reduced fees for covered Prescription Drugs. Refer to your ID card for the name of the administrator of the pharmacy drug plan.

Copays

A copay amount is applied to each covered retail pharmacy drug or mail order drug charge and is shown in the *Schedule of Benefits*. A copay amount is not a covered charge under the medical benefits. Any one pharmacy prescription is limited to the supply shown in the *Schedule of Benefits*. Any one mail order prescription is limited to the supply shown in the *Schedule of Benefits*. Copays may be subject to change based on legislative requirements.

Plan Participants will be charged a dispensing fee and the cost of the ingredients of the drug, in addition to the applicable copay, if a prescription is filled at a non-participating pharmacy or a participating pharmacy when the Plan Participant's ID card is not used.

Mail Order

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Plan Participants significant savings on their prescriptions.

Three-Tier Benefits

Your prescription drug benefit offers formulary drugs. In the formulary, prescription drugs are divided into three categories or tiers: generic (tier 1), preferred brand (tier 2) and non-preferred brand (tier 3). The placement of drugs in the formulary determines what copay will be charged. The Pharmacy Administrator determines the placement of prescription drugs in the formulary at tier 1, 2 or 3. The list of prescription drugs may change from time to time. If you would like a free, updated copy of the formulary and a list of restricted access drugs and devices, please visit our website, www.medcost.com, or call the pharmacy telephone number listed on your ID card.

Generic vs. Brand

Except as required by PPACA, a Plan Participant will be required to pay the brand name copay *plus* the difference in cost between the brand name and generic if he/she chooses brand name when a generic is available. A Plan Participant will not be required to pay the difference in cost between the brand name and generic if the Physician requires brand name dispensing.

Mandatory Specialty Pharmacy

Certain prescriptive drugs (including high cost injectable specialty drugs) must be purchased through the Plan's Specialty Pharmacy program and will not be paid or reimbursed by the Plan if they are not procured through the Plan's Specialty Pharmacy program. This exclusion may be waived for the first specialty drug obtained by a Plan Participant. Under certain circumstances the Plan may pay for the first Specialty drug.

These drugs can be obtained through mail order or at a local retail pharmacy* that is designated by the prescription drug administrator. These drugs are available at discounts significantly greater than those available from other retail or mail order services. Best efforts should be made to research the availability of any specialty drug, as there is limited coverage under the health plan for drugs that can and should be dispensed and reimbursed through this program.

The Specialty Pharmacy can provide medications such as Remicade, Serostim, Rebetrone, Betaseron, Avonex, Enbrel, Chorionic Gonadotropin and many others. Medications can be shipped directly to you or to your Physician.

*Note: For questions or for a complete list of available medications, log on to www.medcost.com and click on the Pharmacy link, or call the pharmacy number listed on your ID card. These drugs are subject to change due to the availability of medications.

Covered Prescription Drugs include, but are not limited to:

- Legend drugs or controlled substances that bear the statement "Caution – Federal law prohibits dispensing without a prescription" except those listed under *Prescription Plan Exclusions*.
- Compounded medications in which at least one ingredient is a legend drug, except minoxidil lotion, progesterone suppositories and any other non-FDA approved experimental drug.

PRESCRIPTION DRUG PLAN LIMITATIONS

The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- Some prescription drugs are subject to supply limits that restrict: (1) the amount dispensed per prescription; (2) the amount dispensed per month's supply; or (3) the amount dispensed per single copay. In most cases, excess quantities will not be covered; however, you may be required to pay an additional copay amount if excess quantities are allowed. You can visit our website, www.medcost.com, or call the pharmacy telephone number listed on your ID card for a list of prescription drugs.
- Some prescription drugs may require Prior Approval in order to be covered. It is very important to make sure that Prior Approval is received before you go to the pharmacy.

Additionally, some prescription drugs may be subject to quantity limits based on criteria developed by the Pharmacy Administrator. Prior Approval is required before excess quantities of these drugs will be covered. If you need quantities in excess of the limit for a drug that is subject to quantity limits, it is important to make sure you have received Prior Approval.

A list of prescription drugs requiring Prior Approval to be covered or requiring Prior Approval for additional quantities can be found at www.medcost.com, or you can call the pharmacy telephone number listed on your ID card.

PRESCRIPTION DRUG PLAN EXCLUSIONS

Exclusions include, but are not limited to:

Administration. Any charge for the administration of any drug or medicine.

Appetite suppressants, anti-obesity drugs, dietary or vitamin supplements. This Exclusion does not apply to prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride, or to any preventive vitamins or supplements that may be required by PPACA.

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

Drugs used for **Cosmetic** purposes.

Devices of any type, even though such devices may require a prescription, other than as required by PPACA.

Experimental, Investigational or not Medically Necessary. This exclusion may not apply to a drug which has been approved by the Federal Food and Drug Administration (FDA) for a specific medical condition, but which is sought to be provided for another medical condition. This is referred to as "off-label use". To be considered a covered expense by the Plan, off-label drugs being prescribed must have been:

1. Approved by the FDA for commercial distribution, and
2. Supported in reputable medical compendia* as effective and accepted treatment for the off-label condition.

**Reputable Medical Compendia includes, but is not limited to:*

Accc-cancer.org	Cancer.gov
Chemoregimen.org	Compendia
FDA.gov	Medscape.com
Medlineplus.gov	NCCN.org
NIH.gov	U.S. Pharmacopoeia

FDA. Any drug not approved by the Food and Drug Administration.

Foreign travel. Care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining prescription drugs.

Injectable supplies. A charge for hypodermic syringes and/or needles (other than for insulin).

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

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

No charge. A charge for Prescription Drugs that may be properly received without charge under local, state or federal programs.

Non-legend uses. A charge for FDA-approved drugs which are prescribed for non-FDA-approved uses.

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

Over-the-counter (proprietary) drugs, medicines or supplies, other than as required by PPACA for certain preventive medications with no cost share.

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

Worker's Compensation. Prescription drug products for any condition, Injury, Illness or mental illness arising out of, or in the course of, employment for which compensation benefits are available for wage or profit including self-employment. The Plan will not pay if you are eligible to receive payment under a Worker's Compensation law or similar legislation, regardless of whether or not you make a claim or receive compensation.

IMPORTANT

Other exclusions may apply to your Plan. Visit www.medcost.com, or call the pharmacy telephone number listed on your ID card.

CLAIMS PROCEDURES AND APPEALS

CLAIM DETERMINATIONS MADE IN ACCORDANCE WITH PLAN DOCUMENTS

The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Plan Documents and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated Covered Persons.

CLAIM DEFINED

A "claim" is any request made by a Covered Person or a Covered Person's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing claims. A request for benefits includes a request for coverage determination, pre-authorization or approval of a plan benefit, or a utilization review determination in accordance with the terms of the Plan.

Requests for eligibility determinations are not claims for benefits. However, when a claim is denied because the Covered Person is not eligible for benefits under the terms of the Plan, the Covered Person has the right to appeal that determination in accordance with the Plan's claims procedures.

CLAIM FILING

Network providers will file medical claims to MedCost Benefit Services for you. If you incur a claim from a Non-Network provider, or a provider that does not file the claim, you can submit the claim by following these steps:

- Complete the Employee's portion of a claim form.
- Have the Physician or Dentist* complete the Provider's portion of the claim form.
- Attach all related bills to the claim form. All bills **MUST** show:
 - Plan name (employer's name) and group number
 - Employee's name
 - Patient's name
 - Provider's name, address, phone number and tax identification #
 - Date(s) of services, diagnosis, type of service rendered including diagnosis or procedure code(s)
 - Charges

Send the completed claim* form to:

MedCost Benefit Services

PO Box 25987

EDI 56205

Winston-Salem, NC 27114-5987

Or by email to mbswebmail@medcost.com.

Claims should be submitted to MedCost Benefit Services as soon as possible after the date of service, preferably within 90 days, but not more than 12 months. When a Plan Participant's coverage terminates for any reason, claims need to be submitted to MedCost Benefit Services within 90 days of termination of coverage.

LIMITATION OF LIABILITY

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "Claim Filing" above, except in the case of legal incapacity of the Covered Person.

URGENT CARE CLAIM

The term "urgent care claim" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next sentence, whether a claim is an urgent care claim is to be determined by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Covered Person's medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

For urgent care claims, the Claims Administrator will notify the Covered Person of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim at the initial benefit

determination level. Notice of a benefit grant or denial may be provided orally, so long as a written or electronic notice of benefit grants or denials is sent to the Covered Person not later than 3 calendar days after the oral notification.

PRE-SERVICE CLAIM

A pre-service claim is any claim for a medical benefit under this Plan that requires approval, in whole or in part, in advance of obtaining medical care. These are, for example, Claims that are subject to predetermination of benefits or pre-certification.

For pre-service claims, generally, the Claims Administrator must notify the Covered Person of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be given at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

POST-SERVICE CLAIM

A post-service claim is a claim for a Plan benefit that is not a claim involving Urgent Care or a pre-service claim; in other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant.

For post-service claims, generally, the Claims Administrator will notify the Covered Person of any adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level.

One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If such an extension is necessary due to a failure of the Covered Person to submit necessary information, the notice of extension shall specifically describe the required information, and the Covered Person shall be given at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of post-service claims.

INCOMPLETE CLAIMS NOTICE DISCLOSURE

The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing.

The Claims Administrator must notify the Covered Person or Covered Person's representative of failure to follow proper claims filing procedures.

- With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim.
- With respect to pre-service claims, notice of incomplete claims will be provided within 5 days of receipt of the claim.

Notification by the Claims Administrator may be oral, unless written notification is requested by the Covered Person or Covered Person's authorized representative.

NOTIFICATION OF ADVERSE BENEFIT DETERMINATION

The Claims Administrator shall provide a Covered person with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Covered Person, the following:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions upon which the determination is based;
- A description of any additional material or information necessary for the Covered Person to perfect the claim and any explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures;
- If the Plan utilizes a specific internal rule, guideline, protocol, or other similar criterion in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or similar criterion will be provided free of charge to the Covered Person upon request;
- If the determination is based on not satisfying the criteria for clinical eligibility for coverage; experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the Covered Person's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- In the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

INTERNAL APPEAL OF DENIED CLAIM AND REVIEW PROCEDURE

A Covered Person will be notified in writing by the Claims Administrator if a claim, or any part of a claim, is denied. If a Covered person does not agree with the reason for the denial, the Covered Person may file a written appeal within 180 days after the receipt of the original claim determination.

An adverse benefit determination is eligible for internal appeal and review if it includes a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

The request for review must contain the Covered Person's name and identification number and the basis for the disagreement along with any information, questions, or comments the Covered Person thinks are appropriate, and should be sent to the office of the Claims Administrator. Copies of any relevant documentation (such as letters, claims, medical records, physician's statements, etc.) should be provided to the Claims Administrator.

The Covered Person's claim appeal will be reviewed and the decision made by someone who was not involved in the initial determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the Covered Person without regard to whether such information was previously submitted or considered in the initial determination.

In addition, in deciding an appeal of any determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or is determined not to satisfy the criteria for clinical eligibility for coverage or is not appropriate, the appropriate reviewer shall consult with a health care professional, who was neither the person who was consulted in connection with the initial benefit determination, nor the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a pre-service claim within 30 days from receipt of the appeal.

The Claims Administrator must notify the Covered Person of the determination of an appeal for a post-service claim within 60 days from receipt of the appeal.

EXPEDITED INTERNAL APPEAL

In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the Covered Person; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Person by telephone, facsimile, or other available similarly expeditious method.

The Claims Administrator will notify the Covered Person, by telephone, of the determination of an expedited appeal within 24 hours from receipt of the expedited appeal. A written notification will be sent to the Covered Person within 3 days after notification by telephone.

EXTERNAL REVIEW

When a Covered Person disagrees with an internal appeal decision, the Covered Person has 4 months following receipt of the appeal notice in which to request an external review. The external review will be conducted by an Independent Review Organization (IRO) that is accredited by URAC (Utilization Review Accreditation Committee).

Within 5 business days of receipt of a request for external review, the Claims Administrator will complete a preliminary review and issue a notification in writing to the Covered Person that the request is complete and eligible for external review.

If the request is not complete, the notification will include information or materials needed to make the request complete. The Covered Person is permitted a 4-month time period to submit the information or materials needed.

When all information has been received, the Claims Administrator will assign the request to an IRO, and will forward all information to the IRO.

The IRO will notify the Covered Person in writing of the request's eligibility and acceptance for external review. The Covered Person is permitted 10 business days in which to submit additional information that the IRO must consider in conducting the external review.

The IRO will forward to the Claims Administrator any additional information provided by the Covered Person and permit the Claims Administrator to reconsider and/or reverse the adverse determination.

If the Claims Administrator reverses the adverse determination, the external review will be terminated. If the Claims Administrator upholds its adverse determination, the external review process continues.

The IRO will provide written notice of its final external review decision within 45 days after the IRO received the request for external review. The notice will be provided to the Covered Person and to the Claims Administrator and will include detailed information that includes the reason(s) and rationale for the decision.

The determination by the IRO is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Covered Person. Claims paid as a result of an IRO determination may be considered eligible claims under this Plan.

EXPEDITED EXTERNAL REVIEW

An expedited external review may be requested for an adverse determination that involves a medical condition of the Covered Person for which the regulatory time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the Covered Person, or would jeopardize the Covered Person's ability to regain maximum function. In other words, an expedited external review may be requested to run concurrently with an expedited internal appeal.

Upon determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO and forward all documentation to the IRO electronically, or via facsimile.

The IRO will review the information and provide a final determination within 72 hours after receipt of the information.

The determination may be communicated to the Covered Person orally, but will also be provided in writing to the Covered Person and the Claims Administrator within 48 hours after the determination is made.

AUTHORIZED REPRESENTATIVES

A Covered Person's authorized representative, including a health care provider, is not precluded from acting on behalf of the Covered Person in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a Covered Person's medical condition as the Covered Person's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether a person has been authorized to act on behalf of a Covered Person.

PAYMENT OF BENEFITS

All benefits under the Plan are payable to the covered employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of incapacity of a covered employee and in the absence of written evidence to the Plan of the qualification of a guardian (or person acting under durable power of attorney) for the covered employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee. In the event of death, the personal representative of the estate will act on behalf of the covered employee.

Benefits for expenses covered under the Plan may be assigned by a covered employee to the individual or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan unless it is in writing and unless it has been received and accepted by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator 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 covered employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will pay benefits in accordance with any assignment of rights under a state Medicaid law.

RECOVERY OF OVERPAYMENTS

If an overpayment is made under this Plan, the Claims Administrator reserves the right to determine and exercise one or all of the following options that it deems necessary to recover the overpayment to the Plan. The Claims Administrator may:

- request the overpayment from any Covered Person to whom such overpayment was made;
- request the overpayment from any provider to whom such overpayment was made; and/or
- deduct the overpayment of benefits from subsequent benefits payable to the Covered Person.

Each Covered Person is deemed, through participation in the Plan, to authorize recovery of overpayments as described above.

COORDINATION OF BENEFITS

When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse is covered by this Plan and by another plan or the couple's covered children are covered by two or more plans, the plans will coordinate benefits when a claim is received.

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. The insurance companies and/or third party administrators involved work together to pay up to 100% of the Plan Participant's covered expenses. This Plan uses the: Standard method: The Secondary plan pays the difference between total allowable expense and the amount paid by the primary plan.

COB applies to health care coverage that provides medical, vision, dental or health benefits by means of:

- A group plan on an insured basis;
- Plans that cover people as a group, including self-funded plans;
- Plans that are arranged through an employer, trustee or union;
- A prepayment plan such as an HMO, POS or PPO;
- Government plans; except Medicaid; and
- Single or family subscribed plans issued under a group plan.

The term "benefit plan" does not include:

- Hospital indemnity type plans;
- Types of plans for students;
- Franchise policies purchased by an individual;
- Automobile policies;
- Homeowners policies; and
- Other individual or family insurance policies for which premiums are paid by the Plan Participant.

For a charge to be considered under COB it must be a Usual, Customary and Reasonable (UCR) Charge as defined in the section entitled Coverage of Medical Expenses and at least part of it must be covered under this Plan.

Note: COB does not apply to Prescription Drug benefits. If a Plan is secondary for medical benefits, the assumption is that the Plan will also be secondary for Prescription Drug benefits.

In order for COB to work, the Plan may release or obtain claim information from any insurance company, organization or person. Accepting benefits under this Plan for incurred medical and/or dental expenses automatically requires a Plan Participant to give this Plan the information it requests about other plans and their payment of covered expenses.

If the Plan Administrator determines that this Plan has paid in error, the Plan will:

- Recover the amount paid to the Plan Participant or another benefit plan when the benefits should have been paid by the other benefit plan; or
- Repay other plans for benefits the Plan should have paid.

Benefits are coordinated on a Benefit Year basis.

Rules for Benefits Plan Payment Order

When two or more plans provide benefits for the same charge, insurance companies and/or third party administrators will follow these rules.

1. Plans that do not have a coordination provision will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the allowed charge:
 - a. The benefits of the plan that covers the person directly (that is, as an Employee, Member or Subscriber) ("Plan A") are determined before those of the plan that covers the person as a Dependent ("Plan B").
 - b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee.

Coverage provided an individual as a Retired Employee and as a Dependent of that individual's Spouse as an Active Employee will be determined under item 2.a. above. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- c. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - d. When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - ii. If both parents have the same birthday, the benefits of the benefit plan that has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - e. When a child's parents are divorced or legally separated, these rules will apply:
 - i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - iii. This rule will be in place of items above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - v. For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
3. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowed charges when paying secondary.
 4. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
 5. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
 6. When there is dual coverage through both COBRA and other group health coverage the rules for determining which plan is primary will be applied in the standard order as they are listed above; in other words, the first rule that describes the situation is the rule to follow.
 - a. Non-dependent or dependent (2.a. above). A plan covering an individual as an employee, member, subscriber, or retiree, is primary and the plan that covers the person as a dependent is secondary.
 - b. Active or inactive employee (2.c. above). A plan covering an individual as an active employee (neither laid-off nor retired) or as the employee's dependent is primary.
 - c. Child covered under more than one plan (2.d. and 2.e. above). The second rule describes which parent's plan will be primary and which will be secondary in a variety of circumstances.
 - d. Continuation coverage. A plan covering an individual as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage (pursuant to state or federal law) is secondary.

MEDICARE AS SECONDARY PAYER

The federal Medicare Secondary Payer (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account in determining whether these individuals are eligible to participate in the Plan, or in providing benefits under the Plan. If you or your covered Dependent is eligible for Medicare, the following MSP rules apply:

If your employer has 20 or more Employees, either Medicare or the Plan can be chosen as the primary coverage for you, if you are an Employee who is eligible for Medicare because you are age 65 or older; and your covered Spouse is age 65 or older, regardless of your age.

If Medicare is elected as primary coverage, the law does not permit the Employer's medical plan to provide benefits supplementing Medicare. Therefore, if you or your Dependent wishes to elect Medicare as your primary coverage, ***you must terminate participation in the Employer's medical plan*** and have Medicare as your only coverage. You should contact the Employer if you wish to terminate your participation in the Plan and have Medicare provide your medical benefits. Otherwise, participation in the Employer's medical plan will continue to provide your primary medical benefits, with Medicare providing supplemental coverage.

If your employer has 100 or more Employees, medical benefits under the Plan will be paid before Medicare benefits for you and your covered Dependent who is under age 65; is eligible for Medicare because of disability; and is covered under the Plan because of your current employment status.

For all employers, medical benefits under the Plan will be paid before Medicare benefits for you or any covered Dependent qualifying for Medicare due to end-stage renal disease. The Plan will remain the primary payer only during the first thirty (30) months after the earlier of: (1) the date renal dialysis treatments are begun; or (2) the date of Medicare entitlement following a kidney transplant.

If this Plan is the primary payer under the above rules, it will provide the same medical benefits that it provides for other Plan Participants who are not entitled to Medicare benefits.

If Medicare is the primary payer for you or any of your covered Dependents, medical benefits will be paid in accordance with the *Coordination of Benefits* provisions of the Plan.

Note: To protect your financial liability it is in your best interest to enroll in Medicare Part B as soon as you become eligible.

MEDICAID

If you or any of your covered Dependents qualify for coverage under Medicaid:

- Your medical benefits under this Plan will be paid before any Medicaid benefits are paid;
- Eligibility and benefits under this Plan are not affected by Medicaid eligibility; and
- Benefits for a Plan Participant who is also covered by Medicaid are subject to the state's rights to subrogation and reimbursement, if Medicaid benefits have been paid first for covered medical charges.

REIMBURSEMENT AND / OR SUBROGATION

- A.** If a Plan Participant receives any benefits arising out of an Injury or Illness (herein, referred to collectively as “Injury”) for which the Plan Participant has or may have any claim or right to recovery:
- payments under this Plan shall be made on the condition that this Plan will be reimbursed out of the proceeds of such claim of right to recovery;
 - payment of benefits under this Plan shall be conditioned upon, and no payments under this Plan of benefits shall be made until acknowledgment in a form specified by the Plan of the agreement of the Plan Participant, and his attorney, to the terms of this Section; and
 - payment of benefits may be revoked, and the Plan may seek refunds of payments, where acknowledgment of the Plan’s rights under this Section is hindered or breached.
- B.** The Plan Participant agrees:
- to refrain from doing anything to prejudice the Plan’s rights to reimbursement or subrogation, or the pursuit of claims directly or indirectly to recover reimbursement of benefits paid;
 - to cooperate fully and exclusively with the Plan and its appointed agents regarding subrogation rights, including executing and delivering all instruments and papers (including the execution of a subrogation form) and do whatever else is necessary to fully protect any and all subrogation or reimbursement rights;
 - that any such funds received will be held in constructive trust for the reimbursement of the Plan inasmuch as the Plan Participant is not the rightful recipient of such funds and should not be in possession of any funds until the Plan has been fully reimbursed;
 - to direct any attorneys or fiscal intermediaries to hold recovery of all funds related to the Injury in trust for the benefit of the Plan, and to direct that such parties deal exclusively with the cost recovery agent for the Plan;
 - to assign to the Plan and its designees all rights against such agents and attorneys to enforce the direction to hold the funds in trust; and
 - to reimburse the Plan in full before any amounts (including, but not limited to, attorney fees, expenses or costs), are deducted from such funds.

The Plan Participant shall be required to cooperate in the timely response to, and submission of, such acknowledgment form, requested related information and executed documents as may be required in order to facilitate benefit payment related to a subrogation claim. Failure to return the required completed and signed subrogation acknowledgment form and other requested documents to the Claims Administrator within 12 months from the date that such form (s) is (are) first sent by the Claims Administrator to the Plan Participant shall result in a loss of coverage for all claims directly related to or arising out of the Injury or Illness. The preceding sentence shall also apply to the obligations of Plan Participant’s counsel under Paragraph E. below. (Please see also Medical Benefit Exclusions under Subrogation.)

C. Recoveries subject to the Plan’s reimbursement claims shall include funds or rights acquired by the Plan Participants (1) from any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant’s own insurance coverage); (2) any person, entity, corporation, plan, association, liability coverage or other at fault party as a result of judgment, settlement, arbitration award, or any other arrangement; or (3) worker’s compensation award, settlement or agreement.

D. Without limiting the preceding paragraph C., this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the Injury which the Plan Participant claims an entitlement to benefits under this Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but is not limited to, the Plan Participant’s own insurance coverage).

E. If the Plan Participant retains an attorney, the attorney must sign the forms specified by the Plan Administrator acknowledging and agreeing to the terms of this Section as a condition of payment of any benefits. By so acknowledging, the attorney indicates agreement that the Plan expressly rejects application of the “make whole” doctrine, the “common fund” doctrine, and any equitable or legal remedies or defenses that would preclude the 100% reimbursement of the Plan out of first dollars recovered from any source, regardless of whether the Plan Participant will recover any funds from the source after reimbursement of the Plan and regardless of whether the

attorney will be compensated or reimbursed for any fees, costs or expenses. The Plan will pay no costs or attorneys' fees, nor reduce its claims for reimbursement.

F. The amount of the Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Plan Participant without regard to whether the Plan Participant is made whole. This paragraph is intended as an express and complete repudiation of the "make whole" doctrine, the "common fund" doctrine, or any equitable or legal remedy or defense to 100% reimbursement and should be interpreted consistent with this intention. If any party or insurance coverage or other source makes payment before this Plan pays, no benefits will be paid under this Plan to the extent of such payment.

G. If any action is taken by the Plan Participant, or his or her representatives to hinder, defeat or compromise the Plan's rights under this Section, the Plan Participant agrees by receipt of benefits under this Plan, that the Plan may deduct from present or future claims for payment under this Plan, or any other plan or program of benefits (e.g., disability, sick pay or paid leave) until the Plan has recouped full reimbursement of all expenditures relating to the Injuries as set forth in this Section.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

Congress passed the *Consolidated Omnibus Budget Reconciliation Act (COBRA)* health benefit provisions in 1986. COBRA contains provisions giving certain former Employees, Retirees, Spouses and Dependent children the right to temporary continuation of health coverage.

Beneficiary

A Qualified Beneficiary generally is any individual covered by a group health plan on the day before a Qualifying Event. A Qualified Beneficiary may be an Employee, the Employee's Spouse and Dependent children, and in certain cases, a Retired Employee, the Retired Employee's Spouse and Dependent children. COBRA continuation coverage is provided subject to your eligibility for coverage. See also Rescission of Coverage under Termination of Coverage.

Qualifying Events

"Qualifying Events" are certain types of events that would cause, except for COBRA continuation coverage, an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the required amount of time that a Plan must offer the health coverage to them under COBRA. A Plan, at its discretion, may provide longer periods of continuation coverage.

The types of qualifying events for **Employees** are:

- Voluntary or involuntary termination of employment for reasons other than "gross misconduct"
- Reduction in the number of hours of employment

The types of qualifying events for **Spouses** are:

- Termination of the covered Employee's employment for any reason other than "gross misconduct"
- Reduction in the hours worked by the covered Employee
- Covered Employee becoming entitled to Medicare
- Divorce or legal separation of the covered Employee
- Death of the covered Employee

The types of qualifying events for **Dependent children** are the same as for the Spouse with one addition:

- Loss of "Dependent child" status under the plan rules

Periods of Coverage

Qualifying Events	Beneficiary	Coverage
Termination Reduced hours	Employee Spouse Dependent child	18 months
Employee entitled to Medicare Divorce or legal separation Death of covered employee	Spouse Dependent child	36 months
Loss of "Dependent child" status	Dependent child	36 months

COBRA outlines procedures for Employees and family members to elect continuation coverage and for employers and Plans to notify beneficiaries. The Qualifying Events contained in the law create rights and obligations for employers, Plan Administrators and Qualified Beneficiaries.

Qualified Beneficiaries have the right to elect to continue coverage that is identical to the coverage provided under the plan. Employers and Plan Administrators have an obligation to determine the specific rights of beneficiaries with respect to election, notification and type of coverage options.

NOTICE PROCEDURES

General Notices

An initial general notice must be furnished to covered Employees, their Spouses and newly hired Employees informing them of their rights under COBRA and describing provisions of the law. COBRA information also is

required to be contained in the Summary Plan Description (SPD) that participants receive. Employers must furnish modified and updated SPDs containing certain plan information and summaries of material changes in plan requirements. Plan administrators must automatically furnish the SPD booklet 90 days after a person becomes a participant or beneficiary begins receiving benefits or within 120 days after the plan is subject to the reporting and disclosure provisions of the law.

Specific Notices

Specific notice requirements are triggered for employers, Qualified Beneficiaries and Plan Administrators when a Qualifying Event occurs. Employers must notify Plan Administrators within 30 days after an Employee's death, termination, reduced hours of employment, or entitlement to Medicare. *A Qualified Beneficiary must notify the plan administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be covered as a Dependent under Plan rules.*

Disabled beneficiaries must notify Plan Administrators of Social Security disability determinations. A notice must be provided within 60 days of a disability determination and prior to expiration of the 18-month period of COBRA coverage. These beneficiaries also must notify the Plan Administrator within 30 days of a final determination that they are no longer disabled.

Plan Administrators, upon notification of a Qualifying Event, must automatically provide a notice to Employees and family members of their election rights. The notice must be provided in person or by first class mail within 14 days of receiving information that a Qualifying Event has occurred.

Election

The election period is the time frame during which each Qualified Beneficiary may choose whether to continue health care coverage under an employer's group health plan. Qualified Beneficiaries have a 60-day period to elect whether to continue coverage. This period is measured from the later of the coverage loss date or the date the notice to elect COBRA coverage is sent. COBRA coverage is retroactive if elected and paid for by the Qualified Beneficiary.

A covered Employee or the covered Employee's Spouse may elect COBRA coverage on behalf of any other Qualified Beneficiary. Each Qualified Beneficiary, however, may independently elect COBRA coverage. A parent or legal guardian may elect on behalf of a minor child.

A waiver of coverage may be revoked by or on behalf of a Qualified Beneficiary prior to the end of the election period. A beneficiary may then reinstate coverage. Then, the Plan need only provide continuation coverage beginning on the date the waiver is revoked.

Covered Benefits

Qualified Beneficiaries must be offered benefits identical to those received immediately before qualifying for continuation coverage.

For example, a beneficiary may have had medical, hospitalization, dental, vision and prescription benefits under Plans maintained by the employer. Assuming a Qualified Beneficiary had been covered by three separate health plans of his former employer on the day preceding the Qualifying Event, that individual has the right to elect to continue coverage in any of the three health plans.

Non-core benefits are vision and dental services, except where they are mandated by law in which case they become core benefits. Core benefits include all other benefits received by a beneficiary immediately before qualifying for COBRA coverage.

If a Plan provides core and non-core benefits, individuals may generally elect either the entire package or just core benefits. Individuals do not have to be given the option to elect just the non-core benefits unless those were the only benefits carried under that particular Plan before a qualifying event.

A change in the benefits under the plan for active Employees may apply to Qualified Beneficiaries. Beneficiaries also may change coverage during periods of open enrollment by the plan.

Duration of Coverage

COBRA establishes required periods of coverage for continuation health benefits. A Plan, however, may provide

longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible to pay for group coverage during a maximum of 18 months for Qualifying Events due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Coverage begins on the date that coverage would otherwise have been lost by reason of a Qualifying Event and can end when:

- The last day of maximum coverage is reached
- Premiums are not paid on a timely basis
- The employer ceases to maintain any group health plan
- Coverage is obtained with another employer group health plan
- A beneficiary is entitled to Medicare benefits

Special rules for disabled individuals may extend the maximum periods of coverage. If a Qualified Beneficiary is determined under Title II or XVI of the *Social Security Act* to have been disabled at the time of a termination of employment or reduction in hours of employment *and* the Qualified Beneficiary properly notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months.

Although COBRA specifies certain maximum required periods of time that continued health coverage must be offered to Qualified Beneficiaries, COBRA does not prohibit Plans from offering continuation health coverage that goes beyond the COBRA periods.

Paying for COBRA Coverage

Beneficiaries may be required to pay the entire premium for coverage. It cannot exceed 102 % of the cost to the Plan for similarly situated individuals who have not incurred a Qualifying Event. Premiums reflect the total cost of group health coverage, including both the portion paid by Employees and any portion paid by the employer before the Qualifying Event, plus 2% for administrative costs. For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased to 150% of the Plan's total cost of coverage.

Premiums due may be increased if the costs to the Plan increase but generally must be fixed in advance of each 12-month premium cycle. The Plan must allow you to elect to pay premiums on a monthly basis if you ask to do so.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the Qualifying Event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments.

The due date may not be prior to the first day of the period of coverage. For example, the due date for the month of January could not be prior to January 1 and coverage for January could not be canceled if payment is made by January 31.

Premiums for the rest of the COBRA period must be made within 30 days after the due date for each such premium or such longer period as provided by the Plan. The Plan, however, is not obligated to send monthly premium notices.

COBRA beneficiaries remain subject to the rules of the Plan and therefore must satisfy all costs related to deductibles, catastrophic and other benefit limits.

Claims Procedures

Health plan rules must explain how to obtain benefits and must include written procedures for processing claims. Claims procedures are to be included in the SPD booklet.

You should submit a written claim for benefits to whoever is designated to operate the health plan (employer, Plan Administrator, etc.). If the claim is denied, notice of denial must be in writing and furnished within 30 days after the claim is filed. The notice should state the reasons for the denial, any additional information needed to support the claim and procedures for appealing the denial.

You have 180 days to appeal a denial and must receive a decision on the appeal within 60 days after that unless the plan:

- provides for a special hearing, or
- the decision must be made by a group that meets only on a periodic basis.

Contact the Plan Administrator for more information on filing a claim for benefits. Complete plan rules are available from employers or benefits offices. There can be charges up to 25 cents a page for copies of plan rules.

Coordination with Other Benefits

The *Family and Medical Leave Act (FMLA)*, effective August 5, 1993, requires an employer to maintain coverage under any "group health plan" for an Employee on FMLA leave under the same conditions coverage would have been provided if the Employee had continued working. *Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a Qualifying Event under COBRA.* A COBRA Qualifying Event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an Employee notifies an employer of his or her intent not to return to work.

Further information on FMLA is available from the nearest office of the Wage and Hour Division, listed in most telephone directories under U.S. Government, Department of Labor; Employment Standards Administration.

Role of the Federal Government

Continuation coverage laws are administered by several agencies. The Departments of Labor and the Treasury have jurisdiction over private sector health plans. The United States Public Health Service administers the continuation coverage law as it affects public sector health plans.

The Labor Department's interpretative and regulatory responsibility is limited to the disclosure and notification requirements. If you need further information on your election or notification rights with a private sector plan, write to the nearest office of the Employee Benefits Security Administration or the

U.S. Department of Labor,
Employee Benefits Security Administration,
Division of Technical Assistance and Inquiries,
200 Constitution Ave., N.W. (Room N-5619)
Washington, D.C. 20210.

The Internal Revenue Service, which is in the Department of the Treasury, is responsible for publishing regulations on COBRA provisions relating to eligibility and premiums. Both Labor and Treasury share jurisdiction for enforcement.

The U.S. Public Health Service, located in the Department of Health and Human Services, has published Title XXII of the *Public Health Service Act* entitled "Requirements for Certain Group Health Plans for Certain State and Local Employees." Information about COBRA provisions concerning public sector employees is available from the:

U.S. Public Health Service Office of the Assistant Secretary for Health Grants Policy Branch (COBRA)
5600 Fishers Lane (Room 17A-45)
Rockville, Maryland 20857

Conclusion

Rising medical costs have transformed health benefits from a privilege to a household necessity for most Americans. COBRA creates an opportunity for persons to retain this important benefit.

Workers need to be aware of changes in health care laws to preserve their benefit rights. A good starting point is reading your plan booklet. Most of the specific rules on COBRA benefits can be found there or with the person who manages your health benefits plan.

Be sure to periodically contact the Plan Administrator to find out about any changes in the type or level of benefits offered by the plan.

DEFINED TERMS

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

Accident is a non-occupational bodily Injury sustained independently of all other causes; that is sudden, direct and unforeseen, and is exact as to time and date.

Adult Woman means 18 years of age and over.

Ambulatory Surgical Center is a licensed facility, either free standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures, and to which a patient is admitted to and discharged from within a 24-hour period.

An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, will not be considered to be an ambulatory surgical center.

Benefit Year means the 12-month period in which covered medical expenses accrue and are counted toward the annual deductible and out-of-pocket limits, if applicable.

Birthing Center means a free standing facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a written agreement with a local Hospital for emergency transfer of a patient or a newborn child, with written procedures for such transfer being displayed and understood by staff members.

Brand Name means a trade name medication.

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

Chiropractic Care is treatment to prevent and treat health problems by using spinal adjustments in order to correct misalignments or subluxations.

COBRA means the *Consolidated Omnibus Budget Reconciliation Act of 1986*, as amended.

Complications of Pregnancy. The Plan considers the following conditions as complications of pregnancy:

- miscarriage or missed abortion;
- eclampsia;
- ectopic pregnancy;
- nephrosis or acute nephritis;
- cardiac decompression;
- hyperemesis gravidarum;
- other pregnancy related conditions that are medically severe.

False labor; occasional spotting; morning sickness; prescribed rest or similar conditions not recognized as a complication of pregnancy are not covered by the Plan.

Cosmetic Dentistry means unnecessary dental procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan. See section entitled *Coverage of Medical Expenses*.

Covered Medical Expense(s). See section entitled *Coverage of Medical Expenses*.

Covered Person means any person meeting the eligibility requirements for coverage as specified in the Plan and properly enrolled in the Plan.

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

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means the covered Spouse and/or covered child or children of the Covered Employee.

Drug Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Durable Medical Equipment means items which:

- are primarily used to serve a medical purpose;
- are generally not useful to a person in the absence of Illness or Injury;
- can withstand repeated use, and
- are appropriate to use in a patient's home for activities of daily living. These are walking, eating, drinking, dressing, toileting, transferring (for example, from wheelchair to bed) and bathing.

Durable medical equipment includes: hospital-type beds; traction equipment; wheelchairs and walkers. Durable medical equipment does not include: exercise equipment and whirlpool baths; air conditioners, dehumidifiers and humidifiers; handrails, ramps, elevators and stair guides; telephones; adjustments made to vehicles; changes made to a home or place of business, or other equipment that has both non-therapeutic and therapeutic use.

Charges for durable medical equipment are covered if its rental (or, at the Plan's option, purchase) is required for therapeutic use, and prescribed by a doctor. However, in no event will rental allowances ever exceed the actual purchase price of the equipment. Only the least expensive item required by the patient's medical condition is covered.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition that may place the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part. Examples include, but are not limited to, heart attacks, poisonings, loss of consciousness, convulsions, and serious falls.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee is any person who is rendering personal services on a permanent basis to the Employer for compensation. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel.

Employer is Botetourt County.

Enrollment Date is the first day an eligible Employee may apply for coverage. If there is a Waiting Period, the first day of the Waiting Period is the enrollment date. If there is no Waiting Period, the date of hire is the enrollment date.

ERISA is the *Employee Retirement Income Security Act of 1974*, as amended. Although this plan is not an ERISA plan, certain plan administration functions (for example, claims procedures, including appeals) are performed in accordance with ERISA guidelines.

Experimental, Investigational or not Medically Necessary. Experimental or Investigational or not Medically Necessary means any supply, medicine, facility, equipment, service, or treatment that is not currently or at the time the charges were incurred recognized as an acceptable, safe, effective, and necessary medical practice for the medical condition for which the supply, medicine, facility, equipment, service, or treatment was provided or is proposed. See Medical Benefit Exclusions.

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

Foster Child is a minor in the primary custody of the covered Employee as assigned by order of a court.

Generic drug means a pharmaceutical product manufactured and sold under its chemical, common or official name, and is approved by the Food and Drug Administration (FDA).

Genetic Information means information about:

- An Employee's genetic tests
- Genetic tests of an Employee's family members (up to and including fourth-degree relatives and a fetus or embryo)
- Any manifestation of a disease or disorder in a family member
- Participation of an Employee or family member in research that includes genetic testing, counseling, or education.

Home Health Care Agency means a Hospital, a public or private agency or other service that is certified (or licensed if licensing is required) by the state in which it is located to provide medical care and treatment in the home. The agency must meet all of the following conditions:

- It has a full-time administrator;
- It is primarily engaged in and licensed by the Community Health Accreditation Program (CHAP) to provide skilled nursing services and other therapeutical services;
- The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan; and
- It maintains a complete medical record on each individual.

Home Health Care Plan means a written program for care and treatment which

- Is required as a result of an Illness or Injury; and
- Is established and approved by the Plan Participant's attending Physician; and
- Is in lieu of continued confinement as a Hospital inpatient.

Hospice means a facility, agency or service that arranges, coordinates and provides special physical, psychological and spiritual needs for dying individuals and their families. A Hospice Care program furnishes palliative or supportive care focused on comfort and not cure.

A Hospice facility provides services and supplies under a Hospice Care program and admits at least 2 unrelated patients.

Hospital is an institution that:

- is operating in accordance with the law of the jurisdiction in which it is located, pertaining to institutions identified as Hospitals;
- is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnosis, treatment and care of Injured or sick persons by or under the supervision of a staff of Physicians or Surgeons;
- continuously provides 24-hour nursing services by graduate registered nurses (RNs);
- maintains facilities on the premises for major operative surgery;
- is not an institution established primarily for the Custodial Care of patients such as a rest home or nursing home but rather renders recognized medical services for the treatment of medical or psychiatric conditions.
- is a Hospital accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA).

The definition of "Hospital" may also include:

- a facility operating legally as a psychiatric Hospital for Mental Health and licensed as such by the state in which the facility operates.
- a facility operating primarily for the treatment of Substance Use Disorders (alcohol and/or drugs) that maintains permanent and full-time facilities for bed care, has a Physician in regular attendance, continuously provides 24-hour day nursing service by a registered nurse, has a full-time psychiatrist or psychologist on the staff and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

A qualified provider of psychiatric rehabilitative treatment:

- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Psychiatric Rehabilitative Treatment Center under Defined Terms.

Note: A psychiatric Hospital for Mental Health or treatment of Substance Use Disorders is exempt from the requirement that it maintains facilities on its premises for major operative surgery.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder or pregnancy of a Plan Participant. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated or separated by at least six (6) weeks. All such disorders existing simultaneously that are due to the same or related causes shall be considered one Illness.

Infertility means the medical inability of a male and female couple to conceive by natural means, or the inability to sustain a pregnancy to term.

Injury means a condition caused by accidental means that results in damage to the Plan Participant's body from an external force. Benefits are payable only for Injuries incurred while not engaged in work-related activities.

A qualified **Institutional Review Board (IRB)** is one that meets all the federal requirements for the operation of an IRB as specified in the Code of Federal Regulations, and has not been disqualified to oversee clinical research by the NIH or FDA and has taken corrective action to rectify any noncompliance issue raised by the NIH or FDA within the past three years and has passed all subsequent NIH or FDA inspections.

Intensive Care Units / Coronary Care Units / Acute Care Units are Hospital areas maintained specifically for critically ill patients. These specialized units have readily available life saving equipment; provide specialty nursing care; contain at least 2 beds; and have no less than one registered nurse (R.N.) on duty at all times.

Intensive Outpatient (or Intensive Outpatient Program). An Intensive Outpatient Program (IOP) is a kind of treatment, service and support program used primarily to treat eating disorders, depression, self-harm and chemical dependency that does not rely on detoxification, and is group-based and non-residential. A typical IOP consists of 3 hours of care 3 times per week, where the patient lives at home or another environment; however, the frequency and length of treatment sessions may vary.

Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant. If a Plan Participant is covered by this Plan on more than one occasion, payments on all occasions shall be counted.

Measurement Period means the defined period during which the Plan measures each Employee's average hours of service per week. If the hours average at least 30 hours of service per week, the Employee will be treated as a full-time Employee and will be eligible for Employee coverage for the subsequent defined Stability Period. The Initial Measurement Period for a new Employee will be the 12-month period beginning on the date of hire. If such Employee is deemed to average at least 30 hours of service per week during the Initial Measurement Period, the Employee will be treated as a full-time Employee and will be eligible for Employee coverage beginning at the end of the administrative period following the Initial Measurement Period.

MedCost Benefit Services, LLC is the third party administrator contracted by the Plan to perform third party administration services for the Plan and to process claims for the Employer.

MedCost, LLC is a preferred provider organization (PPO). This is a network of medical care providers who agree to participate in a special cost containment program. Under this program, Plan Participants who use the services of a PPO (Network) Provider receive greater levels of benefits than those who use a Non-PPO (Non-Network) provider.

Medically Necessary means health care services, supplies or treatment that is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

The fact that a Provider may have prescribed, ordered, recommended or approved certain services or supplies to the Plan Participant does not necessarily mean that such services or supplies satisfy the above criteria. The Plan Administrator has the authority to determine Medical Necessity.

Medicare is the insurance program of medical care benefits provided under Title XVIII of the *Social Security Act of 1965* as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is recognized by the general psychiatric community.

Morbid Obesity (synonymous with "clinically severe obesity") is a condition that is characterized by excessive accumulation and storage of fat in the body and that in an adult is typically indicated by a body mass index (BMI) 40 kg/m² or with being 100 pounds overweight.

Network Hospital, Physician or Provider means a Hospital, Physician or other provider that has an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

Non-Network Hospital, Physician or Provider means a Hospital, Physician or other provider that does not have an agreement with a Preferred Provider Organization to make covered services available to a Plan Participant at reduced rates.

Non-Traditional Medical Service or Services means any practice or therapy that is perceived by its users to have the healing effects of medicine, but does not originate from evidence gathered using the scientific method, is not part of biomedicine, or is contradicted by scientific evidence or established science. Examples include, but are not limited to, homeopathy, naturopathy, and energy medicine.

Observation means services furnished by a Hospital on the Hospital's premises, including use of a bed and periodic monitoring by the Hospital's nursing or other staff, which is reasonable and necessary to evaluate an outpatient's condition, or to determine the need for a possible admission to the Hospital as an inpatient. This is normally less than a 24-hour period but can extend to 48 hours if Medically Necessary. Observations extending longer than 48 hours will be considered as an inpatient confinement and will require precertification.

Outpatient Care and/or Services means treatment or services that do not require confinement in a Hospital.

Partial Hospitalization for the treatment of Mental Disorders and Substance Use Disorders means an Outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Use Disorder when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a facility that is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide Partial Hospitalization services, if required, by the state in which the facility is providing these services. Treatment typically consists of 3 to 6 hours per day for 5 days per week, however the frequency and length of treatment sessions may vary. Partial Hospitalization does not include a charge for room and board since the patient lives at home or in another environment.

Patient Care Services are defined as health care items or services that are furnished to an individual enrolled in a Qualified Clinical Trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Patient Care Services do not include any of the following:

- An FDA approved drug or device shall be a Patient Care Service only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device, or
- Non-health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial, or
- Costs associated with managing the research associated with the Qualified Clinical Trial, or
- Costs that would not be covered for non-investigational treatments, or
- Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial, or
- The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

Physician is a provider that is licensed by the state medical board in the jurisdiction in which the services are provided, such as a medical or dental doctor or surgeon, audiologist, chiropodist, chiropractor, licensed professional counselor, masters level social worker, midwife, nurse practitioner, optometrist, osteopath, Physician's assistant, physical or occupational therapist, podiatrist, psychiatrist, psychologist, and speech therapist, to the extent that such persons, within the scope of their license, are permitted to perform services covered by the Plan. A Physician shall not be a Plan Participant or any close relative of the Plan Participant.

Plan. Botetourt County has established an Employee Welfare Benefit Plan for certain employees of Botetourt County. The benefits described in this booklet constitute benefits available under the Plan and are referred to collectively in this booklet as "the Plan".

Plan Administrator. The person appointed by the Plan Sponsor to be responsible for the management of the Plan in accordance with its terms and for the establishment of its policies, interpretations, practices and procedures. The Plan Administrator may employ persons or firms to process claims and perform other services on behalf of the Plan; however, the decisions of the Plan Administrator will be final and binding on all interested parties.

Plan Participant is any Employee, Retiree, Spouse or Dependent who is covered under the Plan.

Plan Year means the 12-month plan year that is disclosed in the Summary Plan Description and in the Form 5500 Filing, if applicable.

Pregnancy means that physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

Prenatal Care. Care related to Pregnancy before birth, excluding labor, birth/delivery and post-delivery.

Prescription Drugs means injectable insulin and other drugs that have been recognized in the United States Pharmacopoeia, the National Formulary, or New and Non-Official Remedies for the preceding year. These are drugs that under Federal Law may only be dispensed by written order of a doctor and which are approved for general use by the Food and Drug Administration. The drugs must be dispensed on or after the Plan Participant's effective date of coverage under the Plan.

Psychiatric Rehabilitative Treatment Facility. A qualified provider of psychiatric rehabilitative treatment:

- Must be under the direction of a board-eligible or certified psychiatrist or general psychiatrist. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- Hospital licensure is required if the treatment is Hospital based.

See also Hospital under Defined Terms.

A **Qualified Clinical Trial** is defined as a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat a patient who has been diagnosed with cancer, and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
 - One of the United States National Institutes of Health (NIH), or
 - A cooperative group or center of the NIH, or
 - A qualified nongovernmental research entity identified in guidelines issued by the NIH for center support grants, or

- The United States Food and Drug Administration (FDA) pursuant to an investigational new drug exemption, or
 - The United States Departments of Defense or Veterans Affairs,
 - Or, with respect to Phase II, III and IV clinical trials only, a qualified Institutional Review Board (see *Defined Terms*)
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
 4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
 5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
 6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
 7. The clinical trial does not unjustifiably duplicate existing studies, and
 8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient; i.e., is not designed exclusively to test toxicity or disease pathophysiology.

The Plan may require a copy of the Qualified Clinical Trial's study protocol before determining if any benefits are payable by the Plan (see *Patient Care Services*).

Rescission means a cancellation or discontinuance of coverage that has a retroactive effect.

Residential Treatment. Residential Treatment for Mental Disorders and Substance Use Disorders is a rehabilitation program where services are provided in a temporary living arrangement similar to a Skilled Nursing Facility but in which 24-hour nursing services are provided to a patient who is not an immediate danger to self or others, and who needs this structure to maintain his or her current recovery level as determined by a qualified provider of psychiatric rehabilitative treatment.

Residential Treatment Facility. See definition of Hospital.

Retiree means a former covered Employee of the Employer as defined in the Schedule of Benefits.

Skilled Nursing Facility means an institutional provider that meets the following requirements:

- it is approved as a Skilled Nursing Facility by the Medicare Program or the Joint Commission on Accreditation of Hospitals;
- it has a Physician available at all times;
- it has a Registered Nurse (RN) or Physician on full-time duty in charge of patient care;
- it has one or more RN's or LPN's or LVN's on duty at all times;
- it keeps a daily medical record for each patient; and
- is primarily engaged in providing skilled nursing care and related services for convalescent and rehabilitative care and it is not, other than incidentally, a place that provides minimal care, custodial care, ambulatory care, or care for treatment of mental illness.

The term shall also apply to expenses incurred in an institution referring to itself as a Convalescent Nursing Facility or Extended Care Facility or any other similar designation.

Stability Period means the defined period (generally the Benefit Year) during which an Employee who was deemed full-time during the Measurement Period will be eligible for Employee coverage under the Plan. The Initial Stability Period for a new Employee will be the 12-month period following the Initial Measurement Period (plus an administrative period) during which the new Employee was deemed to be a full-time Employee.

Substance Use Disorder / Chemical Dependency is the physiological and psychological addiction to a controlled drug, substance or alcohol. Dependency on tobacco, nicotine and/or caffeine is not included in this definition.

Telemedicine is the practice of medicine using electronic communications, information technology or other means between a Physician in one location and a patient in another physical location. Telemedicine typically involves secure videoconferencing or store-and-forward technology that replicates the traditional Physician-patient interaction.

Temporomandibular Joint (TMJ) is a condition resulting from disease of or Injury to the temporomandibular joint. This joint is a hinge joint that controls the movement of the lower jaw. The joint is controlled by:

- Muscles on each side of the face and those in the back of the head and neck. These muscles open and close the jaw; and
- The position of the teeth in the upper and lower jaw. The teeth determine how far the hinge will close.

Total Disability (Totally Disabled) means:

- In the case of an Employee, an actual or perceived impairment that substantially limits one or more major life activities of the Employee. Total Disability is determined by the employer.
- In the case of a Dependent, an actual or perceived impairment that substantially limits one or more major life activities of the Dependent.

Usual, Customary and Reasonable (UCR). See section entitled *Coverage of Medical Expenses*.

NOTICE OF PRIVACY PRACTICES

**This notice of privacy practices describes how
Medical information about you may be used and disclosed
and how you can get access to this information.
*Please review it carefully.***

This Notice of Privacy Practices (the "Notice") describes the legal obligations of your Group Health Plan (the "Plan") and your legal rights regarding your protected health information held by the Plan under the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* and the *Health Information Technology for Economic and Clinical Health Act (HITECH Act)*. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- 1) your past, present, or future physical or mental health or condition;
- 2) the provision of health care to you; or
- 3) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the Plan Administrator, as designated in your Summary Plan Description.

EFFECTIVE DATE

This Notice is effective August 15, 2013.

OUR RESPONSIBILITIES

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we may share your protected health information with a utilization review or precertification service provider.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care

provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose to certain employees of the Plan Sponsor protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official in response to a court order, subpoena, warrant, summons, or similar process;

- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- and about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your protected health information to researchers when: (1) the individual identifiers have been removed; or (2) when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits. We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice / authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. In most situations, we send mail to the employee / member. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the Plan Administrator. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy;
- or is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply -- for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at the following website: <http://www.medcost.com/>

To obtain a paper copy of this notice, contact the Plan Administrator.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact *the* Plan Administrator. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

POTENTIAL IMPACT OF STATE LAWS

The HIPAA Privacy Regulations generally do not 'preempt' (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV, or AIDS, mental health, Substance Use Disorders/Chemical Dependency, genetic testing, and reproductive rights.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION: The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME: Botetourt County Employee Benefit Plan

GROUP NUMBER: 5070

TAX ID NUMBER: 54-6001153

PLAN YEAR: December 1st through November 30th

PLAN YEAR ENDS: November 30th

BENEFIT YEAR: December 1st through November 30th

PLAN EFFECTIVE DATE: Effective December 1, 2013

Revised and Restated December 1, 2014; Revised and Restated December 1, 2015.

EMPLOYER INFORMATION:

Botetourt County
5 West Main Street, Suite 200
Fincastle, VA 24090
(540) 473-8349

PLAN ADMINISTRATOR

Botetourt County
5 West Main Street, Suite 200
Fincastle, VA 24090
(540) 473-8349

NAMED FIDUCIARY

Botetourt County
5 West Main Street, Suite 200
Fincastle, VA 24090

AGENT FOR SERVICE OF LEGAL PROCESS

Botetourt County
5 West Main Street, Suite 200
Fincastle, VA 24090

THIRD PARTY ADMINISTRATOR

MedCost Benefit Services, LLC
165 Kimel Park Drive
Winston-Salem, North Carolina 27103
(336) 774-4400

CLAIMS ADMINISTRATOR:

MedCost Benefit Services*
PO Box 25987
Winston-Salem, North Carolina 27114-5987
(800) 795-1023

**In compliance with California law, MedCost Benefit Services operates in the state of California as "MedCost Benefit Services d/b/a MBS Third Party Administrators."*