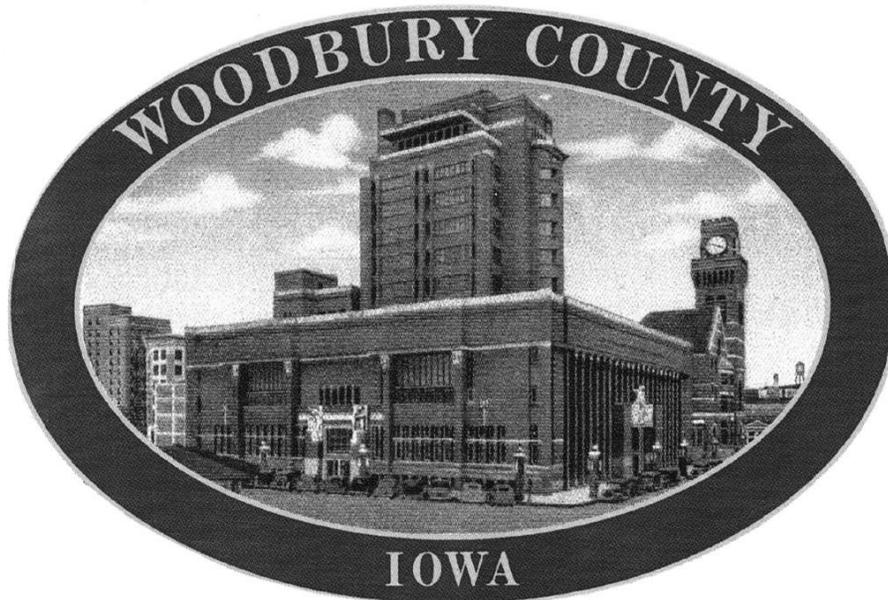


**WOODBURY COUNTY
EMPLOYEES HEALTH BENEFIT PLAN
PLAN B
SUMMARY PLAN DESCRIPTION
(Medical Benefits)**



Effective: June 1, 2013

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ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Woodbury County (the "company" or the "Plan Sponsor") as of June 1, 2013, hereby amends and restates the Woodbury County Employee Health Benefit Plan (the "plan"), which was originally adopted by the company.

Effective Date

The plan document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the plan, hereby adopts this plan document as a general description of benefits available under the plan and is written to assist participants in their understanding of the plan. The details of coverage are limited to the terms and conditions specified in this document. This plan document represents both the plan document and the summary plan description. This document will now be referred to as the plan. This plan document amends and replaces any prior statement of the health care coverage contained in the plan or any predecessor to the plan. Participants may examine the plan or obtain copies of it at any time. It is on file with Woodbury County.

IN WITNESS WHEREOF, the Plan Sponsor has caused this plan document to be executed.

Woodbury County

By: _____

Name: _____

Date: _____

Title: _____

SUMMARY PLAN DESCRIPTION

This booklet contains a general description of benefits available and is written to help participants understand them. The details of coverage are limited to the terms and conditions specified in this Document which is intended to serve as both the Summary Plan Description and plan document. This document will be referred to as the Plan. Participants may examine the Plan or obtain copies of it at any time. It is on file with Woodbury County Human Resources.

This Plan was established for the exclusive benefit of the employees of Woodbury County with the intention it will continue indefinitely. However, Woodbury County reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the Chairman of the Board of Supervisors for Woodbury County and will be binding. If this Plan is terminated, participants may not receive benefits for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against any participant based on: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence), and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable coinsurance amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

INTRODUCTION

This Plan is designed to cover your various health care expenses. This is a self-funded Plan of benefits, which provides coverage for the health care needs of each covered person.

Note: For purposes of this booklet, use of the words "healthcare" or "medical" will also mean "medical and dental".

It is important that you understand this Plan in order to use it effectively. You are encouraged to take the time to read this booklet to gain a basic understanding of your benefits. The "Benefit Summary" which follows provides a brief review of the allowable benefits. The "What Are Covered Expenses?" section provides greater detail regarding your benefits. Specially designated sections outline care not covered by this Plan.

If you have any questions about this Plan of benefits, please contact First Administrators, Inc.

Correspondence can be mailed to:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102 - 0479

or

you may call:

Nationwide.....1-800-206-0827
Sioux City712-279-8400

Grandfathered Health Plan Disclosure

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at: www.healthreform.gov.

PPO INTRODUCTION

This Plan features a preferred provider organization. The preferred provider organization utilizes a network of hospitals and physicians who have contracted to offer their services at a discounted rate. A directory of these providers will be furnished automatically to the employee without charge. If a participant uses preferred providers, benefits, if any, may be paid at a higher level.

The preferred provider network's goal is to contain spiraling health care costs through utilization management and to do this without sacrificing the comprehensive nature of the benefits provided. Participating physicians follow specific guidelines and, when applicable, utilize outpatient services whenever possible, eliminate unnecessary inpatient hospital stays and make wise use of outpatient diagnostic testing and second surgical opinions. A directory of these providers can be furnished to you, without charge.

You always have freedom of choice. You may use the services of any covered provider. However, if you do go to a physician or hospital affiliated with the preferred provider network, your out-of-pocket costs may be less. Please refer to the benefit summary for specific information.

Please see your identification card for your participating provider network. Participating physicians within your PPO area can be located at:

SelectFirst™: www.firstadministrators.com

First Health:
www.firsthealth.com/ccnUsa/index.html

SELECTFIRST™

SelectFirst™ is a fee-for-service Preferred Provider Organization (PPO) designed to provide quality care for you and your dependents, and to help control the rising costs of health care. This Plan has elected to provide health care services through the SelectFirst™ Program. Contracting physicians, hospitals and their staffs have agreed to comply with certain benefit management provisions and in return, participants are directed to them through incentives built into this Plan. A directory of these providers can be furnished to you, without charge.

To locate a physician in your area, please access www.firstadministrators.com. The SelectFirst™ area includes the state of Iowa and the contiguous counties in the states surrounding Iowa.

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless you have been notified, in writing, that another entity is your Plan Sponsor. Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator cannot disclose protected health information to your Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of your Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator will disclose protected health information to your Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by your Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by your Plan to account for disclosures in accordance with 45 CFR § 164.528; and
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, your Plan Sponsor will limit the

use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of your Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards

that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

**WOODBURY COUNTY HEALTH BENEFIT PLAN
BENEFIT SUMMARY PLAN B**

Group #: 78251

Effective Date: June 1, 2013

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated.
Claims must be received within 12 months of the date services were incurred.

MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON-PPO PLAN		
Medical Deductible: (per calendar year) Per Individual Per Family	\$250 \$500	\$250 \$500	Fourth quarter carryover deductible applies. Common accident deductible waiver applies. <i>The PPO, Non-PPO, and Prescription deductibles are mutually satisfying.</i>	28
PPO Office Services Co-pay	\$20/visit	N/A	PPO physician office visits are paid at 100% subject to the PPO Office Services Co-pay and include injections and diagnostic x-ray and laboratory charges, if the charges are associated with the physician's office visit. Services not associated with the physician's office visit will be subject to the appropriate deductible and coinsurance amounts. The co-pay does not apply to the calendar year deductible or the out-of-pocket maximum. Excludes preventive care, well-baby/well-child care.	28
Out-of-Pocket Calendar Year Maximums: - Per Individual/CAL YR - Per Family/CAL YR	\$750 \$1,250	\$750 \$1,250	Includes Calendar Year Deductibles, all coinsurance amount except as specifically excluded. Excludes preadmission certification penalty, prior approval penalty, infertility coinsurance amounts and any co-pays. <i>PPO and Non-PPO out-of-pocket maximums are mutually satisfying.</i>	28
PPO NOTES: 1. When a covered participant is referred by a PPO provider to a non-PPO provider, eligible expenses for the non-PPO provider will be considered at the non-PPO benefit level. 2. When a covered individual resides outside the PPO area, or is traveling outside the PPO area for reasons other than medical care (e.g., business or vacation), and a non-PPO provider is used, eligible expenses from the non-PPO provider will be paid at the non-PPO benefit level. 3. Services and/or treatment provided by a non-PPO provider when there is no PPO provider available within the PPO area will be paid at the PPO benefit level. 4. Ancillary services provided by a non-PPO provider in a PPO facility will be paid at the non-PPO benefit level. 5. Interpretation of x-ray and laboratory results ordered by a PPO provider and provided by a non-PPO provider will be paid at the non-PPO benefit level. 6. Charges for interpretation of x-ray or laboratory services performed in an independent radiology or pathology facility and billed by the PPO physician ordering the services will be considered in the same manner as any other x-ray or laboratory service performed in a PPO provider's office. The eligible expense for all of the above situations, unless otherwise specified, is determined by the provider and type of service, not the benefit level as explained under What Are Covered Expenses?, i.e., they are based on the PPO's fee schedule or discount, the maximum allowable fee or the actual amount charged.				
Utilization Review: Preadmission Certification: Mandatory Outpatient Surgery: Prior Approval:	The Utilization Review program includes Preadmission Certification, Continued Stay Review, Mandatory Outpatient Surgery, Case Management and Prior Approval. Failure to comply with the Hospital Preadmission Certification provision will result in a penalty of 50% of billed charges, not to exceed a maximum penalty of \$750 per confinement. The amount of this penalty is not applicable to the out-of-pocket maximum and is in addition to any other applicable deductible and coinsurance amounts. Pre-certification must take place prior to a planned admission or within two business days following an emergency admission. The Preadmission Certification penalty is waived for maternity lengths of stay of less than 48 hours for normal vaginal delivery and 96 hours for a cesarean section. If a surgical procedure could have been done on an outpatient basis and is performed on an inpatient basis, the total allowable will be reduced by 50%. The amount of this penalty is not applicable to the out-of-pocket maximum. Prior approval is required for cosmetic surgery, growth hormones, morbid obesity surgery, spine and neck surgeries and weight management. Failure to obtain prior approval of these services will result in denied benefits. Prior approval is also required for home health and hospice care. Failure to obtain prior approval of these services will result in a penalty of 50% of billed charges, not to exceed a maximum penalty of \$750. The amount of this penalty is not applicable to the out-of-pocket maximum and is in addition to any other applicable deductible and coinsurance amounts. Prior approval is recommended for treatment of infertility.			24

BENEFIT SUMMARY PLAN B (Cont.)

MEDICAL BENEFITS	PPO PROVIDER	NON-PPO PROVIDER	GENERAL PLAN LIMITS	PAGE
Additional Accidental Injury Benefits	100%	100%	Deductible Waived. Limited to \$300 for services within 90 days. Excludes disease or infection except pyogenic infection from an open wound; injury received in a war; services for which the participant is not legally required to pay.	28
Allergy Benefits	90%	80%	Includes injections, testing and serum dispensed at physician's office.	36
Ambulance Benefits	90%	80%	Limited to local air/ground.	36
Ambulatory/Outpatient Surgery Facility	90%	80%		29
Anesthesia - Operating Surgeon - Assistant Surgeon - CRNA	90% 50% 50% 100%	80% 50% 50% 100%		34
Biologically Based Mental Illness - Inpatient - Outpatient - Office - Residential	90% 90% ** 90%	80% 80% 80% 80%	** See PPO Office Services Co-pay for co-pay and coinsurance percentages. Excludes inpatient room and board charges except inpatient treatment at a Psychiatric Medical Institution for Children (PMIC) for those who are under age 21 and have been admitted by a physician.	36
Birthing Care Center Benefits	90%	80%		29
Cardiac Rehabilitation	90%	80%	Limited to phase I (inpatient) and phase II (outpatient) treatment only; phase III treatment (diet, exercise, healthy lifestyle programs) is excluded. Services and/or treatment must be medically necessary and recommended or ordered by a physician.	36
Chiropractic Benefits - Visits and x-rays - All other services	** 90%	80% 80%	Services must be medically necessary. **See PPO Office Services Co-Pay for co-pay and coinsurance percentages.	36
Consultations	90%	80%		34
Contraceptive Management Benefits	90%	80%	Includes injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive devices (e.g., IUD) and surgical removal of contraceptives. (Oral contraceptives and contraceptive devices dispensed at a pharmacy are payable under the Prescription Drug Benefits.)	36
Dental Services and Oral Surgery Covered Under the Medical Plan	90%	80%	Includes services provided within 72 hours of accidental injury.	29
Diabetic Self-Management Program Benefits	90%	80%	Includes regular foot care examinations by a Doctor or Podiatrist.	30
Durable Medical Equipment	90%	80%	Rental limited to purchase price.	36
Emergency Room Services	90%	90%	Includes physician charges.	-
Hemodialysis (Kidney Disease Treatment)	90%	80%	Includes inpatient treatment and outpatient treatment in a Medicare-approved Dialysis Center.	36
Home Health Care Services	90%	80%	Prior approval required. Nursing visits limited to 2 hours/visit/day.	30
Home Infusion	90%	80%		36
Hospice Care - Respite Care	90% 90%	80% 80%	Prior approval required. Inpatient limited to 15 days/lifetime, outpatient limited to 15 days/lifetime; must be taken in minimum 5-day increments.	30
Hospital Benefits	90%	80%	Limited to semi-private room rate for level of care.	31
Infertility	90%	80%	Prior approval recommended. Does not apply to out-of-pocket maximums.	32

BENEFIT SUMMARY PLAN B (Cont.)

MEDICAL BENEFITS	PPO PROVIDER	NON-PPO PROVIDER	GENERAL PLAN LIMITS	PAGE
Maternity Benefits - Inpatient Newborn Care	90% 90%	80% 80%	Payable for all female participants. Paid separate from mother's charges. Includes nursery room and board, physician visits and circumcision.	32
Mental Health/Chemical Dependency - Inpatient - Outpatient - Office - Partial Hospitalization	90% 90% 90% 90%	80% 80% 80% 80%		32
Nursing Facility Benefits	90%	80%		33
Outpatient Diagnostic X-ray & Lab	90%	80%		33
Physician Services - Inpatient - Outpatient Hospital - Office - Visits, injections, x-rays and laboratory services - All other services	90% 90% ** 90%	80% 80% 80% 80%	Limited to one visit/day per specialty unless additional visits are medically necessary. **See PPO Office Services Co-pay for co-pay and coinsurance percentages.	33
Preadmission Testing	90%	80%		27
Prescription Drug Card Benefit			Charges received through the Prescription Drug Card are subject to the Plan's Calendar Year deductible. Express Scripts is provided with deductible accumulators from First Administrators daily so the information remains current. Once the deductible has been satisfied (using all eligible expenses, both medical and prescription), the member is responsible only for the applicable co-pay or coinsurance amount. The deductible and all prescription co-pays and coinsurance amounts apply toward satisfaction of the participant's out-of-pocket maximum. Once the out-of-pocket maximum is satisfied, the participant will be issued reimbursement for the prescription copays and coinsurance representing the amount as it relates to prescription drug purchases that exceeded his/her out-of-pocket maximum.	40
Retail: - Generic - Formulary - Non-Formulary Oral Chemotherapy Drugs	After the Calendar Year Deductible \$6.00 or 20%, whichever is greater \$25.00 or 20%, whichever is greater \$50.00 or 20%, whichever is greater 10%		Co-pay/coinsurance amounts apply toward the out-of-pocket maximum. Generic drugs are mandatory unless your physician requests "Dispense as Written". If your physician does NOT request "Dispense as Written" and you choose a Formulary or Non-Formulary drug when a Generic drug is available, you must pay the higher co-pay and the cost difference between the two. The Drug co-pays (and coinsurance) apply to the out-of-pocket maximum. Once the out-of-pocket maximum has been satisfied, all eligible co-pay and coinsurance amounts exceeding the out of pocket maximum will be reimbursed.	-

BENEFIT SUMMARY PLAN B (Cont.)

MEDICAL BENEFITS	PPO PROVIDER	NON-PPO PROVIDER	GENERAL PLAN LIMITS	PAGE
Preventive Care	100%**	100%*	<p>* Non-PPO Physician subject to \$20 routine office visit co-pay, applied once annually per person. Calendar year deductible waived.</p> <p>** PPO Physician subject to \$20 routine office visit co-pay, applied once annually per person. Calendar year deductible waived. Active members, cobra participants and non-Medicare retirees must use Preferred Providers to receive benefits for routine services.</p> <p>Limited to participants age 7 and older. Includes: annual routine physical (including pelvic exams and pap smears), prostate exam, blood tests, routine mammography, colonoscopy services for screening of "family history of" and other routine tests done in the physician's office.</p>	34
Private Duty Nursing	90%	80%		36
Prosthetics - Limbs - Other	90% 90%	80% 80%	PPO Medical deductible waived.	-
Surgical Benefits - Inpatient - Outpatient (including office) - Assistant Surgeon - Physician Assistant	90% 90% 90% 90%	80% 80% 80% 80%	<p>Limited to 20% of the eligible expense for the surgical procedure performed.</p> <p>Limited to 10% of the eligible expense for the surgical procedure performed.</p>	34
Therapy Benefits - Respiratory/Inhalation Therapy - Occupational Therapy - Speech Therapy - Physical Therapy - Chemotherapy - Radiation Therapy	90% 90% 90% 90% 90% 90%	80% 80% 80% 80% 80% 80%	<p>Excludes occupational therapy supplies.</p> <p>Limited to parenteral chemotherapy for malignancy.</p>	36
Transplant Benefits - Procurement/Donor Charges - Private Duty Nursing - Air or Ground Ambulance*	90%	80%	<p>Includes cornea; kidney; stem cell; bone marrow, except bone marrow transplants are covered only when they are necessary to treat malignancies of non-Hodgkin's lymphoma, acute lymphocytic or nonlymphocytic leukemia; heart, heart/lung, lung, liver and pancreas.</p> <p>Limited to \$10,000/transplant.</p> <p>*Air/ground ambulance benefits are available for all covered transplant procedures; however, heart, heart/lung, lung, liver and pancreas transplants are limited as stated above.</p>	34
Weight Management	**	n/a	<p>**See PPO Office Services Co-pay for co-pay and coinsurance percentages.</p> <p>Requires prior approval. Benefits limited to Physician visit and recommended Laboratory Services.</p> <p>See "<i>Weight Management</i>" within the "<i>What are Covered Expenses</i>" section for additional limitations.</p>	36
Well-Baby/Well-Child Care	90%	80%	<p>Limited to dependent children under age 7.</p> <p>Deductible and PPO Office Services Co-pay waived.</p> <p>Includes routine exams, routine labs/x-rays and immunizations.</p>	-

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for medical and prescription drug coverage if he/she is an eligible employee who is regularly scheduled to work 30 or more hours each week. If the employee ceases to work, or is no longer scheduled to work 30 or more hours a week, he/she ceases to be a covered employee under this Plan.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first of the month coincident with or following 30 days of employment, providing he/she enrolls for coverage within 30 days following their eligibility date.

In the event that a part-time employee has worked more than 30 days and is promoted to a benefit eligible position, the eligibility waiting period will be waived to allow the employee to become effective for coverage the first of the following month.

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday.

If the employee does not apply to become a covered employee by completing an enrollment form or application within the 30-day period following the waiting period, he/she will not be eligible for coverage under this Plan except during a special enrollment period; during the next following Open Enrollment Period or at a subsequent Open Enrollment Period at a later date, if designated and as determined by the County.

An employee of a newly acquired affiliate or subsidiary will be deemed to have completed his/her waiting period if, on the date of the acquisition, he/she has been a full-time employee, not otherwise ineligible for coverage, for a period equal to the required waiting period of this Plan.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the covered employee's active employment with the County is terminated;
- (b) the last day of the month in which the covered employee ceases to be in a class of employees eligible for coverage;
- (c) the end of the period for which the employee has made contributions if the he/she fails to make the next required contribution;
- (d) the date this Plan is terminated with respect to the County, and there is no successor plan;
- (e) the employee' death; or
- (f) the last day of the month the covered employee voluntarily elects to be terminated from this Plan.

If the covered employee ceases active employment due to an authorized leave of absence, approved disability leave of absence or transfer to an affiliate, participation may be continued pursuant to rules adopted by the County and applied on a uniform basis to all covered employees similarly situated.

If the covered employee wishes to cancel coverage, he/she must notify the County within 30 days prior to the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any health care services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

RETIREE ELIGIBILITY

A retiree is eligible for coverage under this Plan on a basis uniformly applicable to all covered employees who are receiving a pension benefit from the Iowa Public Employee Retirement System or any system replacing IPERS by Iowa law, as a result of his/her disability or formal retirement or who is receiving a Social Security Disability benefit.

Under Iowa Code, Section 509(a), regular employees who retire with Woodbury County, who are enrolled in the County's health plan, and are

under the age of 65 are eligible to continue participation in the County's group health plan at the retiree's expense. As of 01/01/09 retiree's age 65 or over will no longer be eligible for coverage under this Plan.

Under Iowa Code, Section 509(b), the eligible retiree's spouse is also eligible to enroll in the County's health plan, if the spouse is under the age of 65 and the retiree was enrolled in the family plan prior to retiring. The cost of the health plan will be at the participant's expense. As of 01/01/09 retiree's spouses age 65 or over will no longer be eligible for coverage under this Plan.

Once you are a retired employee and you or your dependents become eligible for Medicare, the benefits covered by this Plan are **automatically reduced** by the benefits available to the Medicare-eligible participant under Part A and Part B of Medicare whether or not that person enrolls for Medicare coverage. To avoid having to pay for Medicare-available benefits yourself, it is important that you or your dependent enroll for Medicare Part A and Part B coverage as soon as you become eligible.

RETIREE EFFECTIVE DATE

Coverage will continue under this Plan on the first of the month coincident with or following the date an employee retires provided the eligibility provisions as stated in the previous section have been met.

RETIREE TERMINATION OF COVERAGE

Retiree coverage shall terminate on the earliest of the following dates:

- (a) the last day of the month the covered retiree ceases to be in a class of retirees eligible for coverage;
- (b) the end of the period for which the Retiree has made contributions if he/she fails to make the next required contribution;
- (c) the date this Plan is terminated with respect to the County, and there is no successor plan;
- (d) the retiree's death;
- (e) the last day of the month the covered retiree voluntarily elects to be terminated from this Plan; or
- (f) the date the retiree reaches age 65.

Coverage for dependents of a retiree will continue under this Plan if the retiree's coverage should terminate. Dependents of terminated retiree's will be considered eligible dependents subject to all Plan provisions. If a dependent should lose this coverage they will have COBRA rights starting on the date of loss of coverage.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any health care services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee or retiree may choose to cover his/her dependents (as defined) under this Plan.

A covered employee's or retiree's dependent children may be covered until they reach the age of 26. They may continue coverage if they are unmarried and full-time students in an accredited school.

If both parents are covered under this plan as an employee and/or a retiree, a child can be covered as a dependent of only one parent. No one covered under this Plan as an employee or a retiree can also be covered as a dependent.

Michelle's Law: Coverage of Dependent Students on Medically Necessary Leave of Absence

In the case of an eligible dependent child, this Plan shall not terminate coverage due to a medically necessary leave of absence from, or any other change in enrollment at, a post-secondary education institution that commences while such dependent child is suffering from a serious illness or injury that causes such dependent child to lose student status for purposes of coverage under this Plan, before the earlier of:

- up to one year after the beginning of the leave of absence; or
- the date coverage would otherwise terminate under the Plan.

For the student to qualify for this extension, the Plan must receive written certification from his/her treating physician stating that the student is suffering from a serious illness or injury and that the leave of absence is medically necessary.

A student will qualify for a medically necessary leave of absence from a post-secondary educational institution if the leave of absence:

1. begins while the child is suffering from a serious illness or injury;
2. is certified by a physician as being medically necessary; and
3. causes the child to lose student status for purposes of coverage under the Plan.

If the dependent child's treating physician does not provide written documentation that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary, this Plan will not provide continued coverage.

Adopted Child

The term "dependent" found in this Plan shall include any child meeting the dependent eligibility requirements of this Plan who, prior to age 18, has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO Provision

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient

(participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

- The name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- A reasonable description of the type of coverage to be provided by this Plan to each named child or the manner in which the type of coverage is to be determined; and
- The period to which such order applies.

If the order **is** determined to be a Qualified Medical Child Support Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) If the employee already has coverage in force, the child will be covered as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- (b) If the employee is within the waiting period as specified under the section entitled "Effective Date" the child's coverage will become effective the same date the employee's coverage is effective; or
- (c) If the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Medical Child Support Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's or retiree's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within 30 days after the individual becomes a dependent; or
- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered dependent who becomes eligible as an employee or retiree under this Plan will be considered to have satisfied his/her waiting period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period.

If the employee is absent from active work because of any reason other than his/her medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month the dependent ceases to be a covered dependent as defined by this Plan;
- (b) in the event of a legal separation or divorce, coverage for the employee's or retiree's spouse will cease the last day of the month the event occurred;
- (c) the date this Plan is amended to terminate dependent coverage of a class of employees or retirees of which the participant is a member;
- (d) the last day of the month in which the employee or retiree has made contributions for a dependent's coverage if the next required contribution is not made;
- (e) the date this Plan is terminated with respect to the County, and there is no successor plan;
- (f) death of the dependent;
- (g) the last day of the month the covered dependent voluntarily elects to be terminated from this Plan;
- (h) the date the retiree's spouse turns age 65;
- (i) the last day of the policy year when a dependent no longer meets the definition of dependent; or

If the covered dependent wishes to cancel coverage, he/she must notify the County within 30 days prior to the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any health care services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent. These special enrollment rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity.

This Plan will permit a current employee who is already enrolled in a plan option to enroll in another plan option, if applicable, under this Plan in the event of a special enrollment right.

If an individual moves from a high deductible plan to a low deductible plan mid-year, there will be no reimbursement if the high deductible has already been met.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent that is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee, or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee or retiree having coverage under another group health plan or due to the employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee or retiree with notice of the requirement (and consequences of the requirement) at that time;
- (c) the current employee or dependent lost other coverage pursuant to one of the following events:
 - the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
 - the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);
 - the current employee or dependent moved out of an HMO service area with no other option available;
 - the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);

- the Plan is no longer offering benefits to a class of similarly situated individuals;
- the benefit package option is no longer being offered and no substitute is available; or
- the employer contributions were terminated; and

- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than 30 days after an event, as described in (c) above.

For an eligible current employee, retiree, or dependent who has met **each** of the conditions specified above, this Plan will be effective on the first of the month following the date the other coverage was lost.

This Plan will also permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current employee or dependent lost eligibility under Medicaid or CHIP.

The current employee must request enrollment into this Plan not later than 60 days after the event, as described above.

For an eligible current employee or dependent who has met the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within the required days from loss of coverage.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee and/or spouse may be enrolled at the same time):

- (a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse, and/or other dependents of the current employee may also be enrolled as a dependent

if the spouse and/or other eligible dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of 30 days beginning on the date of marriage. The dependent special enrollment period will be a period of 60 days beginning on the date of birth, adoption or placement for adoption.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, the first of the month following the date of the marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

If the covered current employee has family coverage, newborns are automatically covered under this Plan from the moment of birth provided an enrollment form or application is received within 60 days of the date of the birth.

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee, spouse and/or other eligible dependent may be enrolled at the same time) if:

- the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or CHIP.

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility. (Flexible spending plans and high deductible health plans are not eligible for this special enrollment period.)

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective as of the first day of the month after the request for enrollment is received.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of an dependent child shall not cease because of attainment of the termination age specified in this Plan while your coverage is in

force and the child otherwise qualifies as a dependent, if the child:

- (a) is unmarried;
- (b) is incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical disability; and
- (c) became so disabled prior to attainment of the termination age specified in this Plan.

You must submit to Woodbury County within 30 days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

Woodbury County, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as the County may reasonably require.

Woodbury County will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date you fail to submit any required proof of the uninterrupted existence of the dependent's disability;
- (d) death of the dependent; or
- (e) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

FRAUD OR MISREPRESENTATION OF MATERIAL FACTS

Coverage will terminate immediately if a participant uses this Plan fraudulently or fraudulently misrepresents a material fact in his/her application.

If coverage is terminated for fraud or misrepresentation of a material fact, the Plan has the right to recover any/all claim payments and retains the right to pursue any/all other legal rights, including the right to bring a civil action.

OPEN ENROLLMENT PERIOD

The County will offer an annual enrollment period during which an employee may elect to participate in the Plan. Any otherwise eligible employee who has previously waived coverage may elect to participate in the Plan provided he/she applies during this enrollment period. The enrollment period will be held annually during the month of November with a January 1 effective date.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This section only applies to employers required to comply with the Federal Family and Medical Leave Act.

ENTITLEMENT TO LEAVE

This Act requires an employer which employs 50 or more employees (within a 75 mile radius) to allow an employee who has been employed for 12 months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer, for:

- a) the birth of a son or daughter of the employee and in order to care for such son or daughter;
- b) placement of a son or daughter with the employee for adoption or foster care;
- c) care for a spouse, son, daughter, or parent of the employee, if such spouse, son, daughter, or parent has a serious health condition;
- d) a serious health condition that makes the employee unable to perform the functions of the position of such employee; or
- e) a qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

EXPIRATION OF ENTITLEMENT

The entitlement to leave under subparagraphs (a) and (b) of Entitlement of Leave for a birth or placement of a son or daughter shall expire at the

end of the 12-month period beginning on the date of such birth or placement.

SERVICEMEMBER FAMILY LEAVE

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

COMBINED TOTAL LEAVE

During the single 12-month period as described in Servicemember Family Leave, an eligible employee shall be entitled to a combined total of 26 workweeks of leave under Entitlement to Leave and Servicemember Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other 12-month period.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please contact the employer for more information.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the 24-month period beginning on the date on which the person's absence begins; or
- the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
 - for service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
 - for service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;
 - for service of more than 180 days, no later than 90 days after the completion of the period of service; or

- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than 31 days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant's spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan and not to any other benefits offered under the Plan or by Woodbury County (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Woodbury County, which is the Plan Administrator or First Administrators, Inc., which is the Benefits Services Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be

offered to each person losing Plan coverage who is a "qualified beneficiary." The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this Plan.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee's hours of employment are reduced;
- the employee's employment ends for any reason other than his or her gross misconduct;
- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.)

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notifies the Benefit Services Administrator or Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed, or if the written notice is not provided to the Benefit Services or Plan Administrator during the 60-day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Benefit Services Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Benefit Services Administrator. Under federal law, the participant must have 60 days after the date the qualified beneficiary plan coverage terminates, or, if later, 60 days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

COBRA Department
 First Administrators, Inc.
 PO Box 9900
 Sioux City, IA 51102-0479

The Election Form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than 60 days after the date of the COBRA election notice provided at the time of the qualifying event.

IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date. The Plan will only provide

continuation coverage beginning on the date the waiver of coverage is revoked.

The participant does not have to send any payment with his/her Election Form when he/she elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Benefit Services Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Benefit Services Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having preexisting condition exclusions applied to the participant by other group health plans if he/she has a 63-day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if he/she elect COBRA coverage and does not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of

the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA coverage under the Plan's Medical and Dental components for his/her spouse and children who lost coverage as a result of his/her termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Benefit Services Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Benefit Services Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be

entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Benefit Services Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Benefit Services Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage

of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Benefit Services Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Benefit Services Administrator of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Woodbury County will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period)."

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both

employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to Woodbury County and mailed to:

COBRA Department
First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than 45 days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election. The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Benefit Services Administrator and/or Plan Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and made the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within 45 days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Benefit Services Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be

a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Woodbury County during the covered employee's period of employment with Woodbury County is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the participant family's rights, he/she should keep the Benefit Services Administrator or Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Benefit Services Administrator or the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

COBRA Department
First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479
800-410-4129 (Toll Free)

Woodbury County
Human Resources
620 Douglas Street, Suite 701
Sioux City, IA 51101
712-279-6480

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

INDIVIDUAL HEALTH COVERAGE PROVISION

If the state in which a qualified beneficiary resides does not offer adequate alternative mechanisms for providing access to health benefits for individuals, Federal law requires insurance companies that sell individual health insurance policies in the state where a qualified beneficiary resides to offer a beneficiary, whose continuation coverage is exhausted, the opportunity to purchase an individual health insurance policy from the insurer. The offer of individual health coverage need not be made if the participant is covered under another group health plan, Medicare or Medicaid, or by any other policy of health insurance.

Please contact the Plan Administrator, or your employer, if you are interested in individual health coverage through this provision.

SPECIAL FEATURES TO CONTROL COSTS

This Plan includes several features which help keep medical expenses as low as possible while maintaining a high level of quality care. With these features, this Plan can help you evaluate a provider's recommended treatment plan, make decisions about medical care and lower out-of-pocket costs by using the expertise available from the people who staff the Benefit Services Administrator's utilization review program.

UTILIZATION REVIEW

The utilization review program reviews the medical necessity of hospital inpatient and nursing facility admissions for all medical, surgical, mental health, chemical dependency and rehabilitation admissions. The utilization review provisions do not apply when Medicare is the primary payer.

The utilization review unit is staffed with registered, licensed nurses with at least five years of medical/surgical or mental health/chemical dependency experience.

Their phone lines are available 24 hours per day, every day of the year. The utilization review coordinator can be reached at:

Preadmission Certification

Nationwide1-800-782-9955

Pre-certification does not guarantee benefits. When claims are submitted for payment, they are subject to the terms of this plan which include, but are not limited to, calendar year deductibles, maximum allowable fee amounts, fee schedules and any plan exclusions and limitations in effect at the time services are received. If services are determined to be not medically necessary or not covered by this Plan, benefits will be denied.

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

Preadmission Certification

Each hospital stay, planned or unplanned, requires preadmission certification. Preadmission certification includes physician review, continued stay review and discharge planning.

Planned inpatient stays must be reported to the utilization review unit prior to admission. Unplanned/urgent care (emergency) admissions must be reported **within two business days** following the date of admission.

When you receive care from a SelectFirst™ provider, they will handle the utilization review for you. If a penalty for failure to comply is involved, you are not responsible. However, if you seek care from a non-SelectFirst™ provider, you are responsible for compliance with the utilization review provisions as described in the following sections, and any penalties incurred will be your responsibility.

A request for pre-certification will be accepted from anyone familiar with the patient, but ultimate responsibility remains with the patient. In most cases certification is given during the initial conversation. The nurse reviewer will remain in contact with your physician for the duration of the hospital stay. If, for some reason, an inpatient stay does not meet the criteria, the nurse reviewer will consult with a physician reviewer and respond to the appropriate parties.

Physician Review

Nurse reviewers certify the majority of inpatient stays; but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant (or his/her authorized representative), the attending physician and the hospital are notified immediately. Such a decision can be appealed within 180 days. In this case, the Benefit Services Administrator will contact other physicians to review the admission. If any of these physicians decides to approve benefits, the decision will be reversed.

Continued Stay Review

The utilization review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

Discharge Planning

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and utilization review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

If the participant fails to comply with any part of the Preadmission Certification provision, this Plan will apply a penalty of 50% of billed charges, not to exceed a maximum penalty of \$750 per confinement. The amount of this penalty is not applicable to the out-of-pocket maximum and is in addition to any other applicable deductible and coinsurance amounts.

The Preadmission Certification penalty will be waived for maternity lengths of stay of less than 48 hours for a normal vaginal delivery or 96 hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines if not pre-certified.

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider, acting on your behalf, may be entitled to request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be

filed in writing at the following address no later than 60 days following our decision.

Iowa Division of Insurance
330 Maple Street
Des Moines, Iowa 50319-0065
Fax: 1-515-281-3059
Telephone: 1-515-281-5705

Mandatory Outpatient Procedure

When a physician recommends you or one of your dependents undergo one of the procedures on the following list, you or your physician must contact the Benefit Services Administrator before the procedure is performed.

Unless it can be demonstrated that special risk factors exist and surgery on a hospital inpatient basis is medically necessary, the following procedures must be performed in an outpatient setting:

Otolaryngology/Auditory System

- 21310 - Treatment of closed or open nasal fracture without manipulation.
- 69420 - Myringotomy, including aspiration and/or eustachian tube inflation.
- 69433 - Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; unilateral.
- 69434 - Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia; bilateral.
- 69436 - Tympanostomy (requiring insertion of ventilating tube), general anesthesia; unilateral.
- 69437 - Tympanostomy (requiring insertion of ventilating tube), general anesthesia; bilateral.

General Surgery/Integumentary System

- 11100 - Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed (separate procedure); one lesion.
- 11101 - Biopsy of skin, each additional lesion.
- 12000 - (Series) Repair of superficial wounds.
- 19100 - Biopsy of breast; needle (separate procedure).
- 19101 - Biopsy of breast; incisional.
- 11200 - Excision multiple fibrocutaneous tags.

- 15780 - Abrasion of skin for removal of scars, tattoos, actinic changes (Keratoses), primary or secondary; total face.
- 15800 - Abrasion of skin, acid peel, face neck & shoulders.

Circulatory System

- 37609 - Ligation or biopsy, temporal artery.
- 37700 - Ligation of varicose vein of leg.

General Surgery/Digestive System

- 43235 - Esophagogastroduodenoscopy, diagnostic.
- 43251 - Esophagogastroduodenoscopy, with removal of polyp(s).
- 40510 - Wedge biopsy resection of lip (less than one-third of lip).
- 49500 - Repair inguinal hernia, under age five years, with or without hydrocelectomy; unilateral or bilateral.
- 45300 - 45310
Proctosigmoidoscopy; diagnostic (separate procedure) and minor operative procedures.
- 45330 - 45334
Sigmoidoscopy with small tumor removal.
- 45360 - 45371
Colonoscopy, fiberoptic, beyond 25 cm to splenic flexure; diagnostic procedure and minor operative procedures.
- 45378 - 45386
Colonoscopy, fiberoptic, beyond splenic flexure; diagnostic procedure and minor operative procedures.
- 47000 - Liver biopsy with needle.

Gynecology/Female Genital System

- 57500 - Biopsy, single or multiple, or local excision of lesion, with or without fulguration (separate procedures).
- 57520 - Biopsy of cervix, with or without D & C.
- 58120 - Dilation and curettage, diagnostic and/or therapeutic.
- 59840 - Legal (therapeutic) abortion, completed with dilation and curettage and/or vacuum extraction.
- 58980 - Laparoscopy for visualization of pelvic viscera.

- 58982 - Laparoscopy for visualization of pelvic viscera; with fulguration of oviducts.

Neurosurgery/Nervous System

- 28043 - Excision, benign tumor; subcutaneous.
- 64721 - Neurolysis and/or transposition; median nerve at carpal tunnel.

Orthopedics/Musculoskeletal System

- 11750 - Excision of nail and nail matrix, partial or complete (e.g. ingrown or deformed nail) for permanent removal.
- 11760 - Reconstruction of nail bed; simple.
- 11762 - Reconstruction of nail bed; complicated.
- 25111 - Excision of ganglion, wrist (dorsal or volar); primary.
- 26055 - Tendon sheath incision for trigger finger.
- 26060 - Tenotomy, subcutaneous, single, each digit.
- 26075 - Arthrotomy with exploration, drainage or removal of loose or foreign body; metacarpophalangeal joint.
- 26080 - Arthrotomy with exploration, drainage or removal of loose or foreign body; interphalangeal joint.
- 26160 - Excision of lesion of tendon sheath or capsule (e.g., cyst or ganglion).
- 26455 - Tenotomy, flexor, single, finger, open, each.
- 27373 - Arthroscopy, knee, diagnostic (separate procedure).
- 27376 - Arthroscopy, knee, surgical, with synovial biopsy.
- 27377 - Arthroscopy, knee, surgical, with removal of loose body.
- 28080 - Excision of Morton neuroma, single.
- 28234 - Tenotomy, open, extensor, foot or toe.
- 28285 - Hammertoe operation; one toe (e.g., interphalangeal fusion, fileting, phalangectomy).
- 28290 - Silver or Jones bunionectomy, Hallux valgus (bunion) correction, with or without sesamoidectomy, simple single exostectomy.

- 25100 - Arthrotomy wrist joint, biopsy.
Fractures (Colles' type), upper extremities, toes, fingers, clavicular fractures, lower extremities, ankle or foot bones, fibula.

Urology/Urinary System

- 52000 - Cystourethroscopy.
- 52281 - Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy and injection procedure for cystography, male or female.
- 53020 - 53021
Meatotomy, cutting of meatus (separate procedure), except infant.
- 53025 - Meatotomy, cutting of meatus (separate procedure), infant.
- 53600 - Dilation of urethral stricture by passage of sound, male; initial.
- 53601 - Dilation of urethral stricture by passage of sound, male; subsequent.
- 53620 - Dilation of urethral stricture by filiform and follower, male; initial.
- 53621 - Dilation of urethral stricture by filiform and follower, male; subsequent.
- 53660 - Dilation of female urethra, including suppository and/or instillation; initial.
- 53661 - Dilation of female urethra, including suppository and/or instillation; subsequent.
- 55250 - Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s).

Respiratory System

- 30115 - Excision, nasal polyp(s); extensive, unilateral.
- 30116 - Excision, nasal polyp(s); extensive, bilateral.
- 31620 - Bronchoscopy; diagnostic, rigid bronchoscope.

- 31621 - Bronchoscopy; diagnostic, fiberoptic bronchoscope (flexible).
- 31625 - Bronchoscopy; with biopsy, rigid bronchoscope.
- 31626 - Bronchoscopy; with biopsy, fiberoptic bronchoscope (flexible).

If the surgical procedure (as listed above) could have been performed on an outpatient basis and is performed on an inpatient basis, the total allowable charge will be reduced by 50%.

Prior Approval

Prior approval is *required* for cosmetic surgery, growth hormones, morbid obesity surgery, spine and neck surgeries, and weight management. Prior approval is *recommended* for treatment of infertility. **Failure to obtain prior approval for the required services will result in a penalty of 50% of billed charges, not to exceed a maximum penalty of \$750. The amount of this penalty is not applicable to the out-of-pocket maximum and is in addition to any other applicable deductible and coinsurance amounts.**

Case Management Administration

Individual case management (ICM) is a program designed to assist you with a potentially long-term, high-cost or catastrophic illness and/or injury. The objective is to offer alternatives to traditional care settings. Health care benefits are tailored to meet medical needs while promoting quality and cost-effective outcomes. Case management administration is performed on a case-by-case basis. Benefits may include supplies or services which are not normally a covered benefit under this Plan. Individual case management's goal is to return people to productive lives after a catastrophic illness or injury whenever possible.

Examples of the types of conditions requiring an evaluation are:

- AIDS, brain tumors, cancers, gastrointestinal conditions, head and spinal cord injuries, severe burns and/or strokes.

HOW THE MEDICAL PLAN WORKS

DESCRIPTION OF MEDICAL BENEFITS

Individual Deductible

If the employee chooses individual coverage, unless otherwise specified, he/she will be responsible for the individual calendar year deductible amount specified in the benefit summary before any medical benefits will be paid by this Plan. See the benefit summary for the individual deductible amount.

Family Deductible

If the employee chooses to take family coverage, the total deductible he/she and his/her covered dependents will have to pay in a calendar year will never be more than the family deductible amount specified in the benefit summary; each participant's responsibility will be limited to the individual deductible amount specified in the benefit summary. The family deductible is the same no matter how many dependents are covered. See the benefit summary for the family deductible amount.

Deductible Carryover

Eligible expenses incurred during October, November and December which were applied toward that year's deductible will also be applied toward the next year's deductible.

Common Accident Deductible

If two or more family members are injured in the same accident, only one deductible will be applied to all of the related charges.

PPO Office Services Co-pay

In most cases, each separate visit to a PPO physician's office (includes visits, injections, x-rays and laboratory services) will require a PPO office services co-pay (see "Physician Services" in the benefit summary for other services in the office). This co-pay does not apply to the calendar year deductible or to the out-of-pocket maximum described below.

This co-pay does not apply to office services performed by a Non-PPO physician or to office services incurred outside of the PPO area.

Accident Expense Benefit

The Plan will pay 100% of covered charges up to a maximum benefit, as indicated in the benefit summary, for charges incurred as a result of accidental injuries, provided the participant is treated within 90 days of the accident which caused the injury(s). This benefit is payable for PPO and Non-PPO charges and is not subject to the deductible, PPO Office Services Co-pay or coinsurance amount.

Once the benefit has been exhausted, covered charges will be subject to the applicable deductible, co-pays and coinsurance amounts indicated in the benefit summary.

Coinsurance

Once you have paid your calendar year deductible, this Plan will pay the coinsurance percentages of the covered medical expenses outlined in the benefit summary.

Out-of-Pocket Maximum

There are limits on how much each participant will have to pay per individual, or per family, in allowable medical expenses per calendar year. The benefit summary specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once you meet the out-of-pocket maximum, this Plan pays 100% of the allowable expenses.

Please see the benefit summary for specific details.

WHAT ARE COVERED EXPENSES?

In order for you to receive benefits, the service, supply, device or drug must be medically necessary. Any service, supply, device or drug listed in the Summary Plan Description as otherwise covered in “**What Are Covered Expenses?**” or “**Other Covered Medical Care**” may be excluded if it is not medically necessary in the circumstances. The Benefit Services Administrator determines whether a service, supply, device or drug is medically necessary based upon the terms of the Plan and established medical policies adopted by the Plan Administrator, however, if necessary, the Plan Administrator makes the final determination and that decision is final and conclusive. If the determination of the Benefit Services Administrator is appealed, the Plan Administrator will make a determination. This decision is final and conclusive however participants do retain the right to pursue external and/or judicial review.

The fact that a physician or other health care provider may have prescribed, ordered, recommended or approved certain services or supplies does not necessarily mean such services or supplies are medically necessary nor does it make the service or supply a covered expense.

Following is a summary of allowable expenses under this Plan. If you receive services within the PPO area, eligible expenses for those services are limited to the lesser of the actual amount charged or the amount provided by the fee schedule. If you receive services from non-PPO providers, eligible expenses for those services are limited to the lesser of the actual amount charged or the maximum allowable fee.

AMBULATORY/OUTPATIENT SURGERY BENEFITS

This benefit includes coverage for the facility charges of an "ambulatory surgery center". An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which

does not provide services or other accommodations for patients to stay overnight.

BIRTHING CENTER BENEFITS

Birthing centers provide care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on 24-hour medical back-up in case of complications. The mother and baby are usually discharged from the center within 10-12 hours after birth with home follow-up visits provided. Services may vary from center to center.

Covered services include the room and board charges and eligible expenses for any necessary services and supplies while confined. Benefits are limited to expenses incurred while confined for a period of time not to exceed 24 hours. Expenses incurred beyond the initial 24-hour period may be covered expenses under other benefits of this Plan.

DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The Plan will pay up to the maximum allowable fee for certain dental charges under the medical portion of this Plan for charges incurred by a Participant from a dentist licensed under Chapter 153, Code of Iowa, or a Dentist licensed under similar laws of other states, but limited however, to:

- * jaw and natural teeth repair, if due to an accidental injury for services provided within 72 hours after the accidental injury. Excludes treatment for injuries associated with the act of mastication;
- * the correction of congenital abnormalities of the jaw;
- * reduction of fractures of the facial bones;
- * excision of the mandibular joints;
- * excision of lesions;
- * incision of accessory sinus, mouth, salivary glands or ducts;
- * manipulation of dislocations of the jaw, plastic reconstruction or repair of the mouth or lips necessary to correct accidental injury; and
- * inpatient surgical removal of impacted teeth if hospitalization is required because

Please see the benefit summary for specific details.

of a hazardous medical condition (e.g., hemophilia).

Dental Services to be covered as listed above do not include replacement or repair of teeth, dental structures, dental caries, extractions, corrections of impactions, gingivitis, orthodontia or prostheses.

DIABETIC SELF-MANAGEMENT PROGRAM BENEFITS

Treatment and/or services associated with equipment, supplies, and self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a physician. Benefits shall include:

- Blood glucose meter and glucose strips for home monitoring;
- Diabetes self-management training and education only under ALL of the following conditions:
 - a. The physician managing the participant's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the participant's diabetic condition to ensure therapy compliance or to provide the participant with necessary skills and knowledge to participate in the management of the participant's condition; and
 - b. The diabetes self-management training and education program is certified by the Iowa Department of Public Health. The program must meet the standards for certification of diabetes education programs as outlined by the American Diabetes Association.

Initial training shall cover up to ten hours of outpatient diabetes self-management training within a continuous twelve-month period and up to two hours of follow-up training for each subsequent year.

This does not include programs designed for the primary purpose of weight reduction.

HOME HEALTH CARE BENEFITS

Home health care benefits consist of the following medically necessary services for the

treatment of an injury or illness when prescribed by a physician:

- * part-time nursing care provided in your home by a registered nurse (R.N.), a licensed practical nurse (L.P.N.) or a licensed public health nurse (L.P.H.N.), limited to the maximum specified in the benefit summary;
- * physical, occupational or speech therapy provided in your home;
- * physical, occupational or speech therapy, or the use of medical appliances or equipment, provided on an outpatient basis by a home health agency, a hospital or other facility under an arrangement with a home health care agency;
- * prosthetic appliances and braces;
- * home health aide;
- * inhalation therapy;
- * medical social services;
- * parenteral and enteral nutrition;
- * medical supplies, drugs and medications prescribed by a physician; and
- * laboratory services by or on behalf of a hospital.

Home health care benefits for each participant are limited as specified in the benefit summary.

Home health care benefits will not include any services performed by a member of your immediate family or a person ordinarily residing in your home. Home health care benefits do not include meals, personal convenience items or housekeeping services. No home health care services are payable for the treatment of a mental health or chemical dependency disorder.

HOSPICE CARE BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews and approves the care plan as often as appropriate

Please see the benefit summary for specific details.

to meet the changing needs of the hospice patient and his/her family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator must be obtained prior to commencement of hospice care. Please refer to the benefit summary for the limitations applicable.

The following types of hospice expenses are covered by this Plan:

- * room and board in a hospice facility, hospital or nursing facility;
- * part-time or intermittent nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
- * other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;
- * psychological and dietary counseling;
- * physical and occupational therapy;
- * part-time or intermittent home health aide services consisting mainly of caring for the individual;
- * assessment of the individual's social, emotional and medical needs, and the home and family situation;
- * respite care; and
- * counseling services by Hospice Care Team members for a Participant's family unit.

"Family Unit" means the participant's spouse and children; or if a covered dependent child, such child's parents or siblings whether or not covered under the Plan.

Some items **not** covered under hospice care are:

- * funeral arrangement;
- * pastoral counseling;
- * financial or legal counseling, which includes estate planning or the drafting of a will;

- * homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- * transportation; and
- * housecleaning and maintenance of the house.

HOSPITAL BENEFITS

Hospital benefits include the daily room and board charge for each day of confinement, up to the semi-private room rate of that hospital for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the lowest private room rate for the level of care the patient is receiving. Charges for special care units (e.g., isolation or intensive care rooms and operating rooms) are covered provided the level of care was prescribed by a physician and deemed to be medically necessary.

Hospital confinements must be a result of an injury or illness. This will not apply when charges are incurred in connection with services for a newborn child. If the child is a "well-baby," but the mother remains necessarily confined to the hospital, an additional inpatient day shall also be available for the newborn.

Payment will be made for hospital miscellaneous charges such as oxygen tents and surgical supplies during a period of confinement for which room and board benefits are payable.

Personal convenience items, including, but not limited to, televisions, telephones and admission kits are not payable expenses under this Plan.

Hospital Weekend Admissions

Except for emergencies, admissions to the hospital on a weekend are usually not necessary. Hospital benefits will not be payable under this Plan for Friday, Saturday or Sunday admissions unless the confinement is:

- * medically necessary as determined under this Plan;
- * for a medical emergency;
- * for maternity; or
- * for a next-day surgical procedure.

Please see the benefit summary for specific details.

HOSPITAL PREADMISSION TESTING BENEFITS

To avoid unnecessary time confined in the hospital, it is recommended that you have diagnostic x-ray and laboratory procedures performed on an outpatient basis prior to your hospital admission. All services must be recommended by a physician.

The tests may be performed in your physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab and x-ray center.

INFERTILITY BENEFITS

Covered Charges for services related to diagnosis and treatment of female or male infertility are payable subject to the following conditions:

- (a) amounts which are attributable to coinsurance for Covered Charges related to diagnosis and treatment of female or male infertility shall not be applied towards a Participant's out-of-pocket maximum expense specified in the benefit summary. The coinsurance amounts shall continue to apply even though a Participant has met the out-of-pocket maximum specified in the benefit summary; and
- (b) covered charges for infertility do not include the collection of donor semen, the services of a surrogate parent, freezing of sperm, oocytes (an egg that has not yet undergone maturation) or embryos; drug induced stimulation of ovulation, artificial insemination or any form of in vitro fertilization.

MATERNITY BENEFITS

Expenses incurred by all female participants of this Plan, as the result of pregnancy, will be covered in the same manner as services for any other illness. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum 48-hour hospital confinement following a vaginal delivery or a minimum 96-hour hospital

confinement following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not precertified. However, penalties may be applied to maternity stays that exceed these timeframes, if not pre-certified.

In the event the Participant is discharged from the Hospital or licensed birthing center within 48 hours of normal labor and delivery or 96 hours of a Caesarean section delivery, the Plan will pay for two postpartum home visits by a registered nurse (R.N.) from a Home Health Care Agency or employed by the Participant's Physician, provided the first home visit occurs within 48 hours of discharge. The Participant may elect to stay in the Hospital or licensed birthing center for these minimum time frames. This Plan does not prohibit the discharge of the mother or her newborn earlier than 48 hours (or 96 as applicable) provided the mother and the Physician are in agreement.

Inpatient Newborn Benefits

Expenses incurred for care of a newborn will be considered separate from the mother's maternity expenses and subject to all plan provisions (e.g., deductibles and out-of-pocket maximums) on the same basis as any other medical claim.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

This Plan provides benefits for the following mental health and chemical dependency related services. Benefits are subject to the limits shown on the benefit summary.

Hospital Inpatient Benefits

Benefits include daily room and board charges up to the hospital's semiprivate room rate. Unless otherwise excluded, this Plan will provide benefits for hospital miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable.

Hospital Outpatient and Physician Office Benefits

Unless otherwise excluded, this Plan will provide benefits for medically necessary services including partial hospitalization, therapy and supplies provided in an outpatient or office setting.

Please see the benefit summary for specific details.

Psychiatric Medical Institution for Children (PMIC) Residential Treatment Facility Benefits

This Plan will provide benefits for the daily room and board charges subject to the limits of this Plan. Also included is coverage for miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable. Confinement in a PMIC residential treatment facility for participants under age 21 must be recommended by and under the supervision of a physician. When a participant under age 21 has received services in a PMIC facility, services must be complete before the earlier of the following:

- (a) the date the participant no longer requires services; or
- (b) the date the participant reaches age 22.

Residential Treatment Facility Benefits

With the exception of PMIC benefits, this Plan excludes room and board at a Residential Treatment Facility however charges for miscellaneous outpatient therapy and supplies are an eligible expense.

MORBID OBESITY BENEFITS

Benefits for Hospital services and Physician's services as an Inpatient of a Hospital in connection with the surgical treatment of morbid obesity will be subject to criteria established by the Plan evaluating the need for such Hospital services and Physician's services subject to the following conditions:

- (a) the condition of morbid obesity must be of at least five year's duration immediately prior to the date surgical treatment is sought;
- (b) nonsurgical methods of weight reduction must have been attempted under a Physician's supervision for at least three years immediately prior to the date surgical treatment is sought; and
- (c) the Participant's weight is more than 200% over the ideal weight of a medium frame person based on standard charts used by the life industry.

In no event shall the Plan be liable for payment of benefits hereunder for the surgical treatment of morbid obesity unless the Participant has first obtained the Prior Approval of the Plan that such

surgical treatment shall be deemed eligible for benefits as covered services.

NURSING FACILITY BENEFITS

Benefits are provided for a nursing facility if the care is medically necessary to treat an injury or illness and is prescribed by a physician. Nursing facility benefits for each participant are limited as specified in the benefit summary. Services must be medically necessary and care cannot be of a custodial nature.

Nursing facilities are used by those who require rehabilitation or additional time to recover from an injury or illness but do not need the acute care provided in a hospital.

Payable charges for services include room and board (including general nursing care), special treatment rooms, x-ray and laboratory examinations, physical, occupational or speech therapy, oxygen and other gas therapy and any other services customarily provided by a nursing facility. Room and board charges will be limited to the semi-private room rate of the nursing facility.

Nursing facility benefits do not include services in connection with a mental health or chemical dependency disorder.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

Benefits are payable for outpatient diagnostic x-ray or laboratory services which are provided or recommended by a physician. They may be performed in your physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab or x-ray center.

PHYSICIAN SERVICES

Outpatient Services

Outpatient services by a physician for treatment of an injury or illness are covered benefits of this Plan. Please refer to the benefit summary for specific limitations.

In-Hospital Services

In-hospital services by a physician for treatment of an injury or illness are covered benefits of this Plan. Only one visit per day per specialty will be considered an eligible expense, unless additional visits are deemed to be medically necessary.

Please see the benefit summary for specific details.

This benefit also includes consultations by other physicians, if medically necessary and recommended by the attending physician. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

PREVENTIVE CARE BENEFITS

This Plan has been designed to encourage you to promote good health by providing benefits for certain preventive care.

Routine x-ray and laboratory services will be considered routine preventive care.

Please refer to the benefit summary for a complete list of covered expenses and the limitations applicable to each benefit.

SURGICAL BENEFITS

Surgical benefits include professional fees for performing a covered surgical procedure to treat an injury or illness. Services may be provided on an inpatient or outpatient basis at a hospital, in an ambulatory surgery center or in a physician's office. Surgical benefits include:

- * surgical, operative and cutting procedures, and major endoscopic procedures;
- * treatment of fractures or dislocations or suturing of wounds;
- * medically necessary surgical assistance by a physician. Benefits are not provided if the assistant is an intern, resident or member of the hospital staff or is compensated by the hospital. The surgical procedure and medical condition of the participant must require the services of a surgical assistant. Benefits are limited to 20% of the eligible expense for the assistant surgeon for the surgical procedure performed. The Physician Assistant is limited to 10% of the eligible expense for the surgical procedure performed; and
- * administration of anesthesia in connection with a surgical procedure if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA), other than the operating or assistant surgeon, the physician is not employed or compensated by the institution in which the surgery is performed and the

physician bills for the administration of the anesthetics.

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

Benefits for multiple surgical procedures will be considered at 100% of the eligible expense for the primary procedure and 50% of the eligible expense for any secondary procedures.

Benefits for two like surgical procedures (i.e., bilateral procedures) will be considered at 150% of the eligible expense for the procedure.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998, and, for individuals who choose breast reconstruction surgery, the plan will allow benefits for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema, in a manner determined in consultation with the attending physician and the patient.

TRANSPLANT BENEFITS

Benefits are payable for participant charges of transplant services.

Covered human-to-human transplants include non-experimental and non-investigational procedures as classified by the Health Care Financing Administration of the United States Department of Health and Human Services. However, specified bone marrow transplant procedures will not be excluded to the extent that they are eligible expenses under this Plan and that benefits for these eligible expenses are payable by this Plan. Specified bone marrow transplant procedures include allogenic, autologous, syngeneic and peripheral stem cell transplants if the transplant is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors.

Benefits include:

- * organ and/or tissue procurement. This consists of removing, preserving and transporting the donated organ and/or tissue;
- * air and ground ambulance service. Each participant is limited to the maximum specified in the benefit summary; and

Please see the benefit summary for specific details.

- * private nursing care by a registered nurse (RN) and/or a licensed practical nurse (LPN);

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for procurement and transportation as described above.

When both the recipient and donor are covered by this Plan, services will be covered for each patient with eligible expenses applied to the recipient's coverage. If the donor is covered under this Plan but the recipient is not covered, no expenses will be covered for either the recipient or the donor.

Some items **not** covered under transplant benefits are:

- * lodging and meals;
- * any charges incurred by the donor of an organ or tissue unless otherwise specified by this Plan;
- * any services or supplies related to transplants involving mechanical organs;
- * any charges incurred for the transportation of the living donor for an organ or tissue transplant;
- * services or supplies related to donation of any organ or tissue under the coverage of a donor;
- * expenses associated with the purchase of any organ; and
- * expenses in connection with surgery or treatment classified by the Health Care Financing Administration of the United States Department of Health and Human Services as "experimental," "investigational" or as not "reasonable" or "necessary," however, expenses for specified bone marrow transplant procedures will not be excluded to the extent that they are eligible expenses under the Plan and that benefits for these eligible expenses have been paid by the Plan. Specified bone marrow transplant procedures include allogenic, autologous, syngeneic and peripheral stem cell transplants if the transplant is used to treat leukemia, lymphoma, blood and genetic diseases and solid tumors.

Refer to the benefit summary for specific limitations.

WEIGHT MANAGEMENT

Benefits for treatment and/or services associated with weight loss and nutrition counseling will be eligible based upon the following criteria:

- Prior approval required;
- Participant must be diagnosed by M.D. to possess at least two co-morbidities, or one severe enough to be life-threatening;
- Participant must be age 30 or older;
- Eligible for a single treatment plan per lifetime
- Diagnosis must include Obesity and Co-Morbidity

Please see the benefit summary for specific details.

OTHER COVERED MEDICAL CARE

- (1) **allergy** tests and allergy injections;
- (2) professional air or ground **ambulance** service to the nearest, local adequate hospital or nursing facility for medically necessary treatment of an injury or illness;
- (3) services for **behavioral disorders** (i.e., attention deficit disorder). Behavioral modification is not covered by this Plan;
- (4) **biologically based** mental illness as defined in your Plan booklet;
- (5) unreplaced **blood**, blood plasma and blood plasma expanders and their administration;
- (6) phase I and phase II of **cardiac rehabilitation**;
- (7) **chemotherapy**, limited to parenteral chemotherapy for malignancy;
- (8) manual, mechanical manipulation of the spinal column (**chiropractic** benefits). Treatment exceeding 25 visits or three consecutive months of treatment will require a submission of medical records and additional review by the Benefit Services Administrator;
- (9) charges for injectable **contraceptives** (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive devices (e.g., IUD) and surgical removal of contraceptive devices and implantable contraceptives;
- (10) **drugs** obtainable only with a physician's written prescription and dispensed only by a licensed pharmacist, which are listed in the *U.S. Pharmacopeia* and approved by the United States Food and Drug Administration;
- (11) purchase or rental up to the purchase price of **durable medical** and mechanical equipment which is medically necessary for the treatment of the patient, such as wheelchairs, hospital beds and respirators. Prior approval is recommended;
- (12) **elective sterilizations**, such as tubal ligations and vasectomies;
- (13) **hemodialysis** (kidney disease treatment);
- (14) **home infusion**;
- (15) **immunizations**, limited up to age seven;
- (16) **oxygen** and equipment for its administration;
- (17) papanicolaou smears (**pap smears**).
- (18) **physical therapy** provided by a licensed physical therapist;
- (19) **physician's** professional services provided in a hospital's outpatient or emergency room facility, the physician's office or the participant's home;
- (20) **pre-admission** testing;
- (21) **private duty nursing** services of a registered nurse (R.N.) in or out of a hospital or a licensed practical nurse (L.P.N.) in a hospital. Private duty nursing services are covered only to the extent that they are medically necessary and prescribed by a physician. Payment is not made for services which are custodial;
- (22) **prosthetic appliances** used to aid in the function of or to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function;
- (23) **radiation therapy**;
- (24) **speech, occupational** and **inhalation/respiratory** therapy (limited to a medical condition) under the supervision of a physician. Occupational therapy supplies are not a covered benefit of this Plan;
- (25) medically necessary **supplies**, including, but not limited to, casts, splints, surgical stockings and braces; and
- (26) **surcharges and/or taxes** for reimbursement of uncompensated care costs or other taxes imposed by a governmental body are eligible expenses under this Plan.

Please see the benefit summary for specific details.

Certain medical services are not covered under this Plan. No claims will be paid for:

MEDICAL EXCLUSIONS

- (1) elective, induced **abortion**. This exclusion does not include services related to an abortion where the life of the mother would be endangered if the fetus were carried to term. Medical complications that arise from a covered or non-covered abortion will also be considered eligible expenses.
- (2) **acupuncture** or acupressure therapy;
- (3) **admission** to a Hospital or Nursing Facility primarily for, or the services consist primarily of diagnostic evaluation, physical therapy or occupational therapy, except when such services are medically necessary;
- (4) **bereavement counseling** or services of volunteers or clergy, **except** as otherwise specifically provided for herein;
- (5) **blood**, blood plasma or blood serum, except in the case of hemophilia;
- (6) services or supplies furnished by a **certified registered nurse** (other than a Certified Registered Nurse Anesthetist) which are not private duty nursing services, **except** as otherwise specifically described herein;
- (7) for or in connection with alleviation of **chronic pain** by a pain control center or under a pain control program, for biofeedback or hypnotherapy;
- (8) services and supplies furnished for **complications** of a non-covered procedure;
- (9) **cosmetic services** and/or supplies except for surgery to correct a condition resulting from an accident, within one year of the accident, or to correct a congenital condition of a dependent child covered by this Plan. Breast reconstruction surgery following a mastectomy is not considered cosmetic surgery under this Plan;
- (10) **custodial care**, medical care or treatment and services or supplies for which charges are made by a nursing home, rest home, convalescent home or similar establishment, **except** as otherwise specifically provided for herein;
- (11) **dental care**, dental surgery, dental treatment or for dental appliances, except as otherwise specifically provided for herein;
- (12) **drugs** labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- (13) **experimental or investigative**. Expenses in connection with services or supplies considered "experimental" or "investigational" as defined;
- (14) **eyeglasses** or eye refractions, hearing aids or hearing examinations, orthopedic shoes, arch supports, trusses or examinations for the prescription or fitting thereof;
- (15) bodily injury or sickness resulting from or occurring during the commission of a **felony** by a Participant;
- (16) counseling for persons suffering from **gender identification** problems and services or supplies related to the performance of gender transformation procedures;
- (17) if, with respect to a bodily injury or sickness, a Participant is entitled, or could have been entitled if proper application had been made, to any medical benefit paid by, reimbursed by or provided by or under the authority of any government or any **governmental agency**, except the State of Iowa Medicaid program; such benefit shall discharge the obligation of this Plan as though and to the extent such benefit has been paid hereunder;
- (18) expenses for **learning deficiencies**, behavioral problems and special education;
- (19) services or supplies for **marital**, family or other counseling or other training services;
- (20) for any **medical services** or supplies unless such service or supply is provided for the treatment or diagnosis of a bodily injury or sickness and is prescribed by, or made at the direction of, a Physician, **except** as otherwise specifically provided for herein;
- (21) services or supplies for a Participant covered under this Plan to the extent that the Participant is entitled to have any part of the cost thereof paid by **Medicare**, even though the Participant does not enroll in Medicare, or waives or fails to claim Medicare benefits, including any charges

Certain medical services are not covered under this Plan. No claims will be paid for:

- incurred through Medicare private contracting arrangements;
- (22) services or supplies furnished to a Participant by a Physician who is a **member of the Participant's** immediate family;
- (23) for **missed appointments**;
- (24) unless specifically provided otherwise, no benefits are provided for any charge under **more than one coverage**;
- (25) **non-legend drugs** other than insulin;
- (26) if the Participant is **not obligated** to pay, is not billed or would not have been billed, except for the fact that the person was covered under this Plan;
- (27) for bodily injury or sickness resulting from any release of **nuclear energy**, **except** only when being used solely for medical treatment of a bodily injury or sickness of the Participant under direction and prescription of a Physician;
- (28) for **nutrition counseling**, **except** as otherwise specifically provided herein;
- (29) supplies related to **occupational therapy**;
- (30) air conditioners, humidifiers, dehumidifiers, air purifiers and other **personal convenience** equipment which would be useful to a person in the absence of illness or injury;
- (31) for **personal** service such as radio, television, personal convenience or hygiene items;
- (32) any **prescription refilled** in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order.
- (33) charges incurred **prior to** the individual's effective date of coverage;
- (34) **recreational** or educational therapy or forms of nonmedical self-help or self-cure, including prescription gum or patches used for smoking cessation, or any other smoking cessation aids, all dosage forms;
- (35) surgical correction of **refractive errors**, including but not limited to radial keratotomy and keratomileusis;
- (36) for **reports** or appearances in connection with legal proceedings whether or not an injury or illness is involved; for Physician's telephone consultations and/or travel time; charges in connection with shipping, handling, postage, interest or finance;
- (37) **Retin-A** for individuals 26 years of age or older;
- (38) **reversal** of a vasectomy or tubal ligation or for infertility when the infertility of a Participant or a Participant's reproductive partner is the result of a voluntary sterilization, and sexual impotency/dysfunction;
- (39) **routine foot care**, callus or corn paring, toenail trimming or excision for toenail trimming, treatment of chronic conditions of the foot, such as weak or fallen arches, flat pronated foot metatarsalgia, bunions, hallux valgus, or foot strain, **except** removing nail roots and care prescribed by a licensed Physician treating metabolic or peripheral vascular disease;
- (40) for **special formulas**, food supplements, special diets, laetrile, vitamins, enzymes and any treatment or services rendered for or in connection with Pre-Menstrual Syndrome (PMS);
- (41) treatment of **Substance Abuse** in a facility licensed under Chapter 125, Code of Iowa, if that facility has not been approved by the Plan;
- (42) **transplant procedures**, including those involving implantable and/or inflatable prosthesis, mechanical or animal organs, expenses related to the purchase of an organ, services or supplies related to donation of any organ under the coverage of a donor and services or supplies furnished in connection with the transportation of a living organ transplant donor, **except** as otherwise specifically provided for herein;
- (43) **travel** and lodging costs whether or not recommended by a Physician, **except** as otherwise specifically provided for herein;
- (44) any **treatment** unless that treatment is medically necessary and is generally accepted medical practice, and then only to the extent that the charge for that treatment is based on the maximum allowable fee;
- (45) **vocational rehabilitation**;
- (46) **war**, declared or undeclared, when the Participant is on active or reserve duty in the military of any country;

Certain medical services are not covered under this Plan. No claims will be paid for:

- (47) **weight reduction** and anorectics, **except** as otherwise specifically provided for herein;
- (48) **wigs**, artificial hair pieces, hair loss and restoration, Minoxidil (Rogaine) for the treatment of alopecia;
- (49) illness or injury arising out of or in the course of a participant's employment for which an employer is required to furnish any Hospital, Skilled Nursing Services, Home Health Services or Physician's services or benefits (including **Workers'**

Compensation benefits) or is liable for damages to the Participant, or to the Participant's personal representative, under any applicable federal, state, municipal or other law, even though the Participant has elected to waive or has failed to claim rights to such services, benefits or damages; or services provided in connection with the treatment of illness or injury when the Participant has received or has a right to receive any payment for such services from or on behalf of his/her employer.

PRESCRIPTION CARD SERVICE BENEFITS

Your prescription drug benefit is administered through a program with Express Scripts. Express Scripts utilizes a drug formulary. A drug formulary is a list of safe and cost-effective medications that serves as a guide to physicians when deciding which medications to prescribe for their patients. Based upon the clinical judgment of physicians, pharmacists, and other experts, the list suggests medications the physician might prescribe when there is a choice of medications that produce the same result. A formulary represents the current standards of care regarding appropriate medication options. If your physician prescribes a drug from the formulary, your out-of-pocket costs may be reduced. Please refer to the benefit summary for specific information relating to your cost.

Prescription drugs may be purchased from any pharmacy however utilizing a pharmacy that is contracted with Express Scripts will significantly reduce your up-front and out-of-pocket expense. You will be required to present your I.D. card when obtaining a prescription from a participating pharmacy. The amount you will be

responsible to pay at the time of purchase could vary depending upon whether your deductible and/or out-of-pocket maximum has been satisfied as well as the receipt of other drug and medical claims received by your Benefit Services Administrator.

When you purchase a prescription from a non-participating pharmacy, you will need to pay the full price and submit a claim along with your receipt to Express Scripts. Because discounts are only available when purchases are made through a participating pharmacy, you may not receive full reimbursement for your purchase at a non-participating pharmacy. Claim forms may be obtained through www.express-scripts.com or by calling the Express Scripts telephone number indicated on your I.D. card.

The "Coordination of Benefits" provision **does** apply to this prescription drug benefit.

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

OTHER FACTS YOU SHOULD KNOW ABOUT YOUR HEALTH PLAN

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when you (or a family member) have other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under your other coverage, will not be more than 100% of either our payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance, other group benefit plans (e.g., HMOs, PPOs and self-insured programs), Medicare or other governmental benefits and the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis). To help us coordinate your benefits, you should:

- Inform your provider by giving him/her information about your other coverage at the time you receive services. Your provider will pass the information on to us when the claim is filed.
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

It is important that you provide us with the requested information concerning your other coverage. If you do not give us the necessary information, your claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without a COB clause will be primary.

- (b) The medical benefits of your auto coverage will pay before this plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans. Provided, however, this plan will not cover any medical benefits payable under no-fault auto coverage.
- (c) If both plans have a COB clause, the plan covering you as an employee will be primary over the plan covering you as a dependent.
- (d) If you are the main person covered under both plans (you are not a dependent under either plan), the plan that has provided coverage the longest will be primary.
- (e) The plan covering you as an active participant will pay before the plan covering you as an inactive participant. Participants in retiree plans and COBRA or other similar continuation coverage are considered inactive participants.
- (f) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children.
- (g) If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- (h) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent.

- (i) If none of the guidelines listed above apply, the plan which has covered you or your dependent the longest will be primary.

Special Rules for SelectFirst™ Providers

If this Plan is the secondary payer, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payer, combined with the primary payer's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

RIGHTS OF STATES WITH RESPECT TO GROUP HEALTH PLANS WHERE PARTICIPANTS OR BENEFICIARIES ARE ELIGIBLE FOR MEDICAID BENEFITS

Compliance By Plans With Assignment of Rights

This Plan will provide for payment of benefits with respect to a participant under this Plan to be made in accordance with any assignment of rights made by or on behalf of such participant, or a beneficiary of the participant, as required by a state plan for medical assistance approved under Title XIX (Medicaid) of the Social Security Act.

Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility

When enrolling an individual as a participant or beneficiary of this Plan or in determining or making any payments for benefits of an individual as a participant or beneficiary of this Plan, this Plan will not take into account the fact that the individual is eligible for, or is receiving, medical assistance under Title XIX (Medicaid) of the Social Security Act.

Acquisition By States of Rights of Third Parties

When payment has been made by a state's plan for medical assistance approved under Title XIX of the Social Security Act, in any case in which this Plan has a legal liability to make payment for items or services constituting such Medicaid assistance, payment for benefits under this Plan will be made in accordance with any state law which provides that the state has acquired the

rights with respect to a participant to such payment for such items or services.

MEDICARE AS SECONDARY PAYER

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if you have both Medicare and Woodbury County health coverage under this Plan and Woodbury County has the minimum required number of employees as described in the following paragraphs.

Working Aged

This provision applies only to group health plans of employers with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

- Age 65 or older.
- A current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

This provision applies only to group health plans of employers that had at least 100 full-time, part-time or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- Under age 65.
- A recipient of Medicare disability benefits.
- A current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- The beneficiary has Medicare coverage as an ESRD patient.
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact your employer or the Social Security Administration.

MEDICARE AS PRIMARY PAYER

When the foregoing subsection "Medicare as Secondary Payer" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense. Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age 65, other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section when the participant is eligible for Medicare benefits. Benefits could be reduced if the participant:

- has not enrolled or applied for benefits under Medicare;
- has failed to take any action required by Medicare to qualify for benefits; or
- received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such participant.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses and

benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision (***established so a covered person cannot profit from this Plan***), the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- * any persons to whom such payments were made; or
- * any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of participants, plan beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "participant(s)") or a third party, where other

insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the participant agrees the Plan shall have an equitable lien on any funds received by the participant and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, the participant agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the participant is entitled, regardless of how classified or characterized.

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

The Plan may in its own name or in the name of the participant commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the participant fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or,
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

Right of Reimbursement

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

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

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

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

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

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

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the participant, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant, such that the death of the participant, or filing of bankruptcy by the

participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

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

Obligations

It is the participant's obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

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

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

CONFORMITY WITH LAW

The laws of the State of Iowa shall govern this Plan. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

CLAIMS FILING AND APPEALS

ASSIGNMENT OF BENEFITS

This Plan accepts all assignments of benefits to make direct payments to providers of services, including, but not limited to, physicians, hospitals and nursing facilities. If a PPO contract requires automatic assignment of benefits, all benefit payments will be made directly to the PPO provider. The participant does not have to assign benefits. Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of bankruptcy or other event happening at any such time and such amount would not be enjoyed by him/her, then the Plan Administrator in its sole discretion may terminate his/her interest in any such amount and will hold or apply it to or for the benefit of the participant, his/her spouse, children or other dependents, or any combination of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

Claims must be received within 12 months of the day charges are incurred to be eligible for benefits.

Whenever a participant obtains healthcare services, he/she should present the Plan's Benefit ID Card. Instructions for billing by the provider of care or the member are included on the Benefit ID Card. Physicians, hospitals and clinics may file claims for the participant; however, the participant is ultimately responsible for the filing of claims.

A paper healthcare claim will be considered filed on the date it is received by the Benefit Services Administrator. For a claim repriced or identified as non-PPO by a PPO vendor, the claim will be considered filed on the date it is received from the PPO network. Electronic claims are considered received the day subsequent to the transmission of the claim by the provider. There

are specific fields that are required for each type of claim to constitute a "clean claim." This criteria is available, upon request, from the Benefit Services Administrator.

For claims not filed by the provider of service, the following steps should be taken to ensure that claims are filed correctly. Woodbury County will provide the employee with claim forms.

- (1) Claims must be received within 12 months of the day charges are incurred.
- (2) Complete the personal section of the claim form. Be sure to indicate any other group, franchise or association-sponsored plan the participant has in addition to this Plan.
- (3) Sign the assignment of benefits portion of the claim form. Unassigned benefit payments will be directed to the participant. All benefit payments for claims submitted by a PPO provider will automatically be made directly to the PPO provider unless proof of payment is submitted.
- (4) Either have the provider complete the appropriate section of the claim form or attach the original itemized bill or pharmacy receipt to the claim form. This bill (or pharmacy receipt) should identify the patient, the date, the nature of treatment or service and the amount charged. Canceled checks or cash register receipts do not contain the information needed to process a claim.
- (5) Sign and date the form in the authorization section.
- (6) Use a separate claim form for each member of the family and retain a copy for the participant's files.
- (7) For hospital admissions, present the Benefit ID Card to the admitting clerk.
- (8) If the participant needs assistance in completing the claim form, please contact Woodbury County or the Benefit Services Administrator.
- (9) All claims should be filed according to the instructions on the Benefit ID Card.

Please contact the Human Resources Department for claims or questions regarding Life, Supplemental Life and Long Term Income Protection insurance.

CLAIM DETERMINATION

This section describes the procedures the Plan will follow in making a determination on a claim for benefits. A claim is any request for a plan benefit, made by a claimant or a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims.

Upon receipt of a claim, the Plan must respond to the participant within the time frames stated below. These time frames are the maximum number of calendar days in which a determination must be made and communicated to the participant.

Urgent Care Claims

An urgent care claim is 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 participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The participant's physician may determine if the claim is an urgent care claim. Otherwise, an individual acting on behalf of the Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, may make the determination.

A response to an urgent care claim will be provided within 72 hours of the receipt of the claim by the Plan. If a participant fails to provide sufficient information, the Plan will notify the participant within 24 hours of receiving the claim of the specific information necessary to complete the claim. The participant will then have 48 hours to provide the additional information and, once received, a decision will be communicated within 48 hours. Without complete information the claim will be denied.

Urgent care claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Pre-Service Claims

A pre-service claim is any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If the participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the participant of the failure and the proper procedures to be followed within five days of such failure. Otherwise, a response to a pre-service claim will be provided within 15 days of the receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial 15-day period, the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary due to the failure of the participant to provide sufficient information, the Plan will notify the participant of the specific information necessary to complete the claim. The participant will then have 45 days to provide the additional information and, once received, a decision will be communicated within 15 days. Without complete information, the claim will be denied. If the Plan does not provide a notice of extension within 15 days, the participant has the right to begin an appeal as outlined in the Claim Review Procedures section.

Pre-service claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Concurrent Care Claims

Concurrent Care is an ongoing course of treatment (inpatient or outpatient) to be provided over a period of time or number of treatments which has been approved by the Plan. If ongoing treatment benefits are reduced or terminated by the Plan before the end of the period for which such treatment was approved, the participant will be notified sufficiently in advance to allow the participant to appeal the adverse determination and obtain a decision on the appeal before the reduction or termination goes into effect.

If a participant requests an extension of a course of treatment that is an urgent care claim as defined above, the Plan will notify the participant of its determination within 24 hours of the Plan's receipt of the request.

If the participant requests an extension of a course of treatment that is not an urgent care claim, the request will be considered a new claim and will be subject to the time frames and procedures that are appropriate to the type of claim (i.e., pre-service or post-service). Please refer to the appropriate section for timelines and procedures specific to these types of claims.

Post-Service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

The Plan will respond to a post-service claim within 30 days of receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial 30 day period and will be given the date by which a decision is expected. If the Plan does not provide a notice of extension within 30 days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedure section.

If a participant fails to provide sufficient information, the participant will be notified within 30 days of the Plan's receipt of the claim of the specific information necessary to complete the claim. The participant will then have 45 days from receipt of the notice to provide the additional information and, once received, a decision will be communicated within 15 days. Without complete information the claim will be denied.

NOTIFICATION OF DECISION

If a claim has been wholly or partially denied, written notification will be provided by the Plan which will describe:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provision(s) on which the denial is based;
- (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) an explanation of this Plan's claims review procedure;
- (e) a copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or, in lieu thereof, a statement that such information is available free of charge upon request;
- (f) an explanation of the scientific or clinical judgment relied upon in denying the claim based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such

information is available free of charge upon request; and

- (g) for urgent care claims, a description of the expedited appeal process.

For urgent care claims, this information may be provided to the participant orally, provided that written notification is furnished within three days of the oral notification.

CLAIMS REVIEW PROCEDURE

Claim Inquiry

If a claim has been wholly or partially denied and the claimant does not agree with the reduction, or if the claimant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the claimant has the right to a full and fair review. An adverse benefit determination is a denial, reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the Notification of Decision. This request must be submitted within 180 days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the Urgent Care Claims section below.

The claimant may submit written comments, documents or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in the case will be consulted. If the decision on appeal is adverse, the participant may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the claimant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be

communicated by telephone, facsimile or other similarly prompt method.

Notification of the decision on appeal will be provided within 72 hours of the Plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within 30 days of the Plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within 60 days of the Plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the Plan that will describe:

- (a) specific reason(s) for adverse determination;
- (b) reference to the specific Plan provision(s) on which determination is based;
- (c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents, records and other information relevant to the participant's claim for benefits;
- (d) a statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures;
- (e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request;

- (f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (g) a statement that reads as follows: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance agency."

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider, acting on your behalf, may be entitled to request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following our decision.

Iowa Division of Insurance
330 Maple Street
Des Moines, Iowa 50319-0065
Fax: 1-515-281-3059
Telephone: 1-515-281-5705

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by you, and include all the information required in our Authorized Representative Form. This form is available from Woodbury County. In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative form. An assignment of benefits, release of information or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

DEFINITIONS

"**ACCIDENTAL INJURY**" means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance.

"**ACTIVE DUTY**" means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

"**ACTIVELY AT WORK**" means the performance of all the duties that pertain to the participant's work at his/her normal place of employment or any other location required by the employer.

"**ACTIVELY AT WORK ON A FULL-TIME BASIS**" means an employee must work for his/her employer at his/her usual place of work or such other place or places as required by his/her employer in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of this employer.

"**ADOPTED CHILD(REN)**" means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

"**ADVERSE BENEFIT DETERMINATION**" means a denial, reduction or termination of a benefit.

"**ALLOWABLE EXPENSES**" mean the portion of an eligible expense actually payable by this Plan after taking into account co-pay, deductible and coinsurance amounts, any applicable benefit maximum or maximums and any other limitation or exclusion provided for under this Plan. This calculation is based on the payment method utilized by this Plan.

"**ALTERNATE RECIPIENT**" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

"**AMBULATORY/OUTPATIENT SURGERY FACILITY**" provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.

"**AMENDMENT**" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by the County.

"**BENEFIT PERIOD**" is the same as the calendar year. It begins on the day the participant's coverage goes into effect and starts over each January 1.

"**BENEFIT SERVICES ADMINISTRATOR**" means First Administrators, Inc., an Iowa corporation.

"**BENEFITS**" mean those medically necessary services and supplies that qualify for payment under this Plan.

"**BIOLOGICALLY BASED MENTAL ILLNESSES**" means schizophrenia, schizoaffective disorders, major depressive disorders, bipolar disorder, pervasive developmental disorders, obsessive-compulsive disorders, and autistic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

"**BIRTHING CENTER**" provides obstetrical care and related services on an outpatient basis.

"**BRAND NAME PRESCRIPTION DRUG**" means the pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

"**BUSINESS ASSOCIATE**" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 Code of Federal Regulations Part 160.103).

"**CALENDAR YEAR**" means the 12-month period commencing January 1 and ending the next following December 31.

"**CHEMICAL DEPENDENCY**" means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Revised*, (DSM-IV-R), published by the American Psychiatric Association or subsequent revisions to DSM-IV-R.

"CHEMICAL DEPENDENCY FACILITY" is a licensed, free-standing facility approved by this Plan to provide treatment for chemical dependency conditions.

"CHILD(REN)" means children of a covered employee including natural children, adopted children, stepchildren, foster children or other children who are principally dependent upon the employee/retiree, his/her covered spouse or former spouse for their financial support and maintenance, as defined by the Internal Revenue Service for tax purposes.

"CLAIM" means any request for a Plan benefit made by a claimant or a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims.

"COINSURANCE" means the percentage(s) of eligible expenses allocable to the participant and the employer after any applicable co-pays, calendar year deductibles or non-compliance penalties have been applied.

"COMMUNITY MENTAL HEALTH CENTER" or "MENTAL HEALTH CLINIC" means a facility established for the purpose of providing consultation, diagnosis and treatment in connection with a mental health disorder and approved as such by a state department or agency having authority over such facilities.

"CONTINGENCY OPERATION" means designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.

"CO-PAY" means the predetermined amount paid by the participant on a per item or per service basis.

"COSMETIC SERVICES" means treatment or surgical procedures intended to improve physical appearance, but which do not treat illness, restore, or materially improve a deficiency in normal physiological function. Cosmetic services performed to alleviate psychological distress are not covered by the Plan.

"COUNTY" means Woodbury County, an Iowa municipality, or any entity with or into which said county may be merged or consolidated provided, however, that such successor entity elects in writing to adopt the Plan and to be bound by the provisions contained herein

"COVERED DEPENDENT" means a spouse or a dependent child who has satisfied the definition of dependent and the eligibility requirements specified in this Plan.

"COVERED EMPLOYEE" means any employee who is eligible for benefits as specified in this Plan.

"COVERED EXPENSES" means those expenses covered by this Plan, including the hospital, surgical, medical, dental, and vision care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not medically necessary, are experimental or investigational in nature, or if they exceed the maximum amount considered by this Plan. See also the definitions of eligible expenses and allowable expenses.

"COVERED SERVICEMEMBER" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

"CREDITABLE COVERAGE" means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

"CUSTODIAL CARE" helps a participant with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not a benefit under this Plan.

"DEDUCTIBLE" is the amount for covered services a participant pays before this Plan begins paying benefits.

"DEPENDENT" means

- (a) the spouse of an employee/retiree; or
- (b) children of an employee/retiree.

"DISABILITY" means:

- (a) in the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the material duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience; or
- (b) in the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

"DOMICILIARY CARE" means inpatient institutional care provided to the participant not because it is medically necessary but because care in the home setting is not available, is unsuitable or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- * home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- * home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible enough to care for the child or because someone in the home has a contagious disease; or

- * the family is unwilling to care for a person in the home, such as where a family does not want to handle a child who is difficult to manage.

"DURABLE MEDICAL EQUIPMENT" means medical equipment not otherwise excluded which is designed for repeated use, is primarily and customarily used to serve a medical purpose and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan, the Benefit Services Administrator may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers and other similar convenience items are not considered durable medical equipment.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

"ELECTIVE SURGICAL PROCEDURE" means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. If the course or manner of treatment of a condition is expressly excluded by this Plan, is not medically necessary, is experimental, investigational or otherwise regarded by the Plan Administrator to be ineffective treatment for the condition or not included because of any reason described in the Plan, then the expense for the treatment is not eligible. See the definition of allowable expenses for a description of how this Plan computes the portion of an eligible expense which it will pay.

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

"EMPLOYEE" means any individual who is employed by the County.

"ENROLLMENT DATE" or **"DATE OF ENROLLMENT"** means the first day of a participant's waiting period under this Plan (typically the date the employee's employment begins). The enrollment date for anyone who enrolls during a special enrollment period is the first day of coverage under this Plan.

"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES" means a service, supply, device or drug that has progressed to limited human application but has not achieved recognition as being proven in clinical medicine.

To determine whether a service, supply, device or drug is experimental or investigational, the Benefit Services Administrator shall refer to established medical policies including whether a service, supply, device or drug meets the following criteria:

- It has final approval from the appropriate regulatory bodies.
- The scientific evidence must permit conclusions concerning its effect on health outcomes.
- It improves the net health outcome.
- It is as beneficial as any established alternatives.
- The health improvement is attainable outside the investigational setting.

In applying these criteria, the Benefits Services Administrator shall be guided by the terms of the Plan and by established medical policies adopted by the Plan Sponsor.

"EXTRACTION" means removing a tooth from the oral cavity.

- * **Simple Extraction** - Uncomplicated removal of a tooth.
- * **Surgical Extraction** - Removal of a tooth by means of surgical methods, usually involving the turning of a flap or removal of bone.

"FEE SCHEDULE" means a contractually specified amount payable for physician's services within the PPO area.

"FOSTER CHILD" means a child whom the employee is raising as his/her own, who resides in the employee's home and for whom the employee has full parental responsibility and control. A foster child must have been placed in the employee's home by the appropriate governing authority.

"FULL-TIME STUDENT" means a covered dependent that meets the age requirements of this Plan, is enrolled in a full-time course of study in an approved institution of higher learning.

"GENERIC PRESCRIPTION DRUGS" mean the pharmaceutical products manufactured and sold under their common chemical or non-proprietary name. The generic equivalent of a brand name drug must meet the same standards for safety, purity, strength and effectiveness as the brand name drug. Both have the identical chemical composition and therapeutic effect.

"HIPAA" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

"HOME HEALTH AGENCY" is a Medicare approved association or organization which provides skilled nursing care in the participant's home.

"HOME HEALTH SERVICES" are health care services performed in a participant's home by a home health agency.

"HOSPICE" provides care (usually in the home) for patients who are terminally ill and have a life expectancy of six months or less. The Hospice must be accredited by the Joint Commission on

Accreditation of Healthcare Organizations (JCAHO), be Medicare approved and/or be licensed by the state in which it operates.

"HOSPICE SERVICES" include home health care plus respite services.

"HOSPITAL" is an institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or ill persons. The facility must be licensed as a hospital under applicable laws.

"HOSPITAL CONFINEMENT" means being registered for a minimum of 18 hours as a bed patient in a hospital, nursing facility or chemical dependency facility upon the recommendation of a physician or as a patient in a hospital because of a surgical operation or receiving emergency care in a hospital for an injury within 48 hours after the injury is received.

"ILLNESS" means any bodily disorder, bodily injury, disease or mental health condition including pregnancy and complications of pregnancy.

"IMMEDIATE FAMILY" means a participant's legal spouse, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMMUNIZATION" is an injection with a specific antigen to promote antibody formation to make the participant immune to a disease or less susceptible to a contagious disease.

"IMPACTED TOOTH" means a tooth that is positioned or wedged against another tooth or covered by bone or soft tissue so that it cannot erupt.

"INFERTILITY" means the inability or diminished ability to produce offspring.

"INJURY" means a physical condition which is the result of an accident caused by an external force and occurring while this Plan is in effect with respect to that participant and which results in loss covered by this Plan; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INPATIENT" means being confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board

charges by the hospital, nursing facility or chemical dependency facility.

"INTENSIVE CARE UNIT" means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (R.N.) and other nursing care and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

"LEGEND DRUGS" mean those drugs classified within any of the five categories for drugs that come under the jurisdiction of the most recent Controlled Substance Act and which may only be dispensed by a licensed pharmacist upon the written prescription of a physician. Compounded medications of which at least one ingredient is classified as noted above shall be included.

"LICENSED PRACTICAL NURSE" means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the participant's home or who is a member of the participant's immediate family.

"LICENSED PUBLIC HEALTH NURSE" means a professional nurse who has the right to use the title registered nurse (R.N.), other than one whom ordinarily resides in the patient's home or who is a member of the patient's immediate family and who has extended their study in the public health field.

"LIFETIME" means the period of time a person is actually a participant under this Plan, commencing with the original effective date, and is not intended to imply or suggest benefits beyond an individual's termination date or this Plan's termination date as herein specified.

"LOCAL AIR AND GROUND AMBULANCE" means medically necessary transportation to an appropriate inpatient or outpatient facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers: if no other method of transportation is appropriate; the services necessary to treat the injury or illness are not available in the hospital, nursing facility or chemical dependency facility in which the participant is an inpatient or

outpatient; and the point of destination is the nearest one with adequate and appropriate methods of care.

"MAXIMUM ALLOWABLE FEE" means the lesser of:

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries, or shared savings contracts for the services; or
- The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area; or
- The fee based on 150% of the Medicare reimbursement as determined by the fee Medicare allows for the same or similar services provided in the same geographic area.

"MEDICALLY NECESSARY" means a service, supply, device or drug that a physician or other health care provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - Credible scientific evidence published in peer-review medical literature generally recognized by the relevant medical community;
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
 - Any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

In applying these criteria, the Benefits Services Administrator shall be guided by the terms of the Plan and by established medical policies adopted by the Plan Sponsor.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the Benefit Services Administrator and the Plan Administrator reserve the right to approve the least costly alternative.

Note: Any service, supply, device or drug listed as otherwise covered in **"What Are Covered Expenses?"** or **"Other Covered Medical Care"** may not be eligible for benefits if such service, supply, device or drug is investigational or experimental.

"MEDICARE" is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

"MENTAL HEALTH DISORDER" means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised* (DSM-IV-R), or subsequent revisions to DSM-IV-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

"NEXT OF KIN" means the nearest blood relative of an individual.

"NON-PPO MEMBER" or "NON-PPO PROVIDER" means any health care provider who is not a contracting member of a preferred provider organization utilized by this Plan.

"NOTIFICATION OF DECISION" means delivery or furnishing of information by the Plan to an individual regarding decision of the claim for benefits. Information is considered delivered or furnished as of the date it is mailed by or verbally provided by the Plan.

"NURSING FACILITY" provides continuous skilled nursing services as ordered and certified by an attending physician. A registered nurse (R.N.) must supervise services and supplies on

a 24-hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

"OFF-LABEL DRUG USE" means the use of a drug for a purpose other than that for which it was approved by the FDA.

"OUT-OF-POCKET MAXIMUM" is a specified amount that the participant must pay for covered services, out of his/her pocket, in a calendar year. The out-of-pocket maximum is satisfied as indicated on the benefit summary. Once the participant meets the out-of-pocket maximum, this Plan pays 100% of the allowable expenses.

"OUTPATIENT" means a participant who receives treatment at a hospital, clinic or dispensary or other medical care facility but is not confined to continuous 24-hour inpatient care.

"PALLIATIVE" means affording temporary relief but not a cure.

"PARTIAL HOSPITALIZATION" means an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization.

"PARTICIPANT" means any covered employee and any covered dependent.

"PHYSICIAN" means a provider of medical services legally licensed to practice medicine and surgery or any other legally licensed practitioner of the healing arts rendering, within the scope of the individual's license, services which are covered under this program and for which benefits are required to be provided by law when rendered by such a practitioner. In no event will the term "physician" include a resident physician, intern, or other individual in training, or a member of the participant's family.

"PLAN" means this Woodbury County Employees Health Benefit Plan, as set forth herein, and as from time to time amended, which is administered by the Benefit Services Administrator.

"PLAN ADMINISTRATOR" means the person or persons appointed to administer this Plan, if any, otherwise, the County.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also

see Part II, 45 Code of Federal Regulations Part 164.501).

"PLAN YEAR" means the 12-consecutive-month period commencing on July 1 and ending on June 30, identified by the Plan for keeping its records.

"POST-SERVICE CLAIM" means any claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

"PPO AREA" means the area encompassing the contracted PPO providers.

"PPO MEMBER" or "PPO PROVIDER" means a contracted health care provider who is a member of a preferred provider organization utilized by this Plan.

"PREADMISSION TEST" means any diagnostic test or study required as part of a hospital's admission policy or which is necessary for a scheduled surgical procedure and which is performed prior to a hospital confinement.

"PRE-EXISTING CONDITION" means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

"PREFERRED PROVIDER ORGANIZATION" or "PPO" means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the County and the preferred provider organization.

"PRESCRIPTION DRUG" means covered legend drugs, medicines or medications prescribed by a physician and dispensed by a licensed pharmacist necessary to treat an injury or illness.

"PRE-SERVICE CLAIM" means any claim for a benefit under this Plan, with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"PRIVATE DUTY NURSING" means continuous bedside nursing service, rendered by one nurse to one patient, either in a hospital, nursing facility, hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an inpatient setting.

"PROCUREMENT COSTS" mean those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

"PROSTHESIS" or "PROSTHETIC APPLIANCE" means a device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term "prosthesis" include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses or examinations for the prescription or fitting thereof.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

"PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN (PMIC)" means a Residential Treatment Facility licensed by the State of Iowa that provides mental health treatment and services to children in residence who have been diagnosed with a biologically based mental illness.

"PSYCHOLOGIST" means a person who holds a Ph.D. in clinical psychology, is recognized by the American Board of Examiners in Professional Psychology and who is licensed in and performs such services in accordance with the laws of the state in which such services are provided.

"QUALIFIED BENEFICIARY" means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent

jurisdiction or a state agency that administers child support enforcement programs.

"REGISTERED NURSE" means a professional nurse who has the right to use the title registered nurse (R.N.), other than one whom ordinarily resides in the patient's home or who is a member of the patient's immediate family.

"REHABILITATION INSTITUTION" means a legally constituted and operated institution (other than a hospital) established to provide medical treatment for patients who require inpatient care for chemical dependency, but do not currently require continuous hospital services for such condition, and which has permanent facilities for inpatient medical care on the premises, including 24-hour nursing service under the supervision of a full-time registered nurse (R.N.), and maintains daily medical records on all patients. In no event will the term "rehabilitation institution" include any institution, or part thereof, which is used principally as a rest facility or nursing facility, a facility for the aged or one providing primarily custodial care.

"REINSURER" means the insurance company providing the excess risk insurance maintained by the County.

"RESIDENTIAL TREATMENT FACILITY" means a 24-hour live-in facility generally used for the treatment of mental health and/or chemical dependency disorders.

"ROOM AND BOARD" means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

"SECOND SURGICAL OPINION" means a consultation with another physician which the Plan may allow to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

"SPECIAL CARE UNIT" means a section, ward or wing within the hospital which is separated from other hospital facilities and:

- (a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illnesses;
- (b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- (c) provides room and board and constant observation and care by a registered

nurse (RN) and other specially trained hospital personnel.

"SPOUSE" means a person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence. In addition, if the covered employee has a common law marriage, coverage for the employee's spouse and dependent children may be obtained. However, certain requirements must be met, as determined by the County and by the laws of the state in which the employee lives. Please contact the County for specific details.

"STEPCHILD" means any biological or adopted child of the spouse of an employee.

"SURGICAL PROCEDURE" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

"TERMINALLY ILL" means having a life expectancy of six months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

"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 participant or

the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

"VISIT" means each attendance to the covered participant by a physician or medical practitioner (i.e., consultation or treatment).

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

"WELL-BABY CARE" or "WELL-CHILD CARE" means pediatric preventive services appropriate to the age of a child from birth to age two as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans which provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

INFORMATION REQUIREMENTS

Named Fiduciary/ Plan Sponsor:	Woodbury County 620 Douglas Street, Room 701 Sioux City, IA 51101
Employer Identification #:	42-6005221
Plan Name:	Woodbury County Employees Health Benefit Plan
First Administrators, Inc. Group Number:	78251
Plan Year Ends:	June 30
Participants:	Eligible employees, eligible retirees and their covered dependents
Plan Administrator and Agent for Legal Process of Plan:	Woodbury County Board of Supervisors 620 Douglas Street, Room 104 Sioux City, IA 51101
Plan Costs:	The Plan Sponsor pays the costs of this Plan. Participants under a “self-pay” (e.g., Retirees, COBRA Participants) are responsible for the full amount of contributions.
Type of Plan:	Employee Health Benefit Plan
Type of Administration:	Contract Administration
Third Party Administrator:	First Administrators, Inc. P.O. Box 9900 Sioux City, IA 51102-0479
Authority to Amend Plan:	Chairman of the Board of Supervisors, Woodbury County
Administration and Plan Administrator Authority:	<p>The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.</p> <p>The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.</p> <p>The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.</p>

If the employer is unable to fund this Plan, the participant may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

NOTES