

CITY OF TYLER
DENTAL PLAN

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

EFFECTIVE: JANUARY 1, 2010

HEALTHFIRST
Third Party Administrators

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SPECIAL NOTICES

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

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

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the COBRA Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification - Notification of the Qualifying Event must be made in writing. Notice may be made by submitting the "Notice of Qualifying Event" form and mailing it to the COBRA Administrator. This form is available, without charge, from the Plan Sponsor.

Content - Notification must include an adequate description of the Qualifying Event or disability determination. In the case of a disability determination, a copy of the Social Security Administration determination of disability must be included. The Qualified Beneficiary must also provide any additional information as the Plan deems necessary for making the appropriate determination with regard to the Notice e.g. evidence of the specific event which would indicate a divorce decree, child's birth certificate, etc.

Delivery of Notification - Notification must be received by the COBRA Administrator at:

Mail: Conexis
6191 North State Highway 161
Suite 400
Irving, TX 75038

Website: www.conexis.org

The phone number for assistance with COBRA questions is 1-877-722-2667.

Time Requirements for Notification - Should an event occur (as described above), the Employee or family member must provide Notice to the designated recipient within a certain time frame. The notice must be received in the COBRA Administrator's office within sixty (60) days of the occurring event.

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or a General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see “Effect of the Trade Act” in the **COBRA Continuation Coverage** section of the Plan’s Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or a General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

Who to Contact for Additional Information

A Plan participant can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan (the “Contract Administrator”). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

DENTAL BENEFIT SUMMARY

SCHEDULE OF DENTAL CARE BENEFITS

Benefits for Eligible Dental Care Expenses are provided based on the schedule presented below:

Calendar Year Deductibles

Basic and Major Services	\$50 per person \$150 per family
Orthodontia Services	\$50 per child

The Calendar Year Deductible is waived for Preventive Services.

Dental Plan Maximums

Calendar Year Maximum Benefit for Preventive, Basic and Major Services, combined	\$1,200
Lifetime Maximum Benefit for Orthodontia Services	\$1,000

Dental Plan Maximums are per Covered Person. Once a Calendar Year Maximum has been met, no further benefits are payable for expenses incurred by that Covered Person in that same Calendar Year. Once the Orthodontia Services Lifetime Maximum has been met, no further Orthodontia benefits are available to that Covered Person.

Benefits for Eligible Expenses

Preventive Services	100% of eligible expenses; the calendar year deductible does not apply.
Basic Services	80% of eligible expenses incurred, after the basic and major services deductible is satisfied.
Major Restorative Services	50% of eligible expenses incurred, after the basic and major services deductible is satisfied.
Orthodontia Services (limited to Dependent Children)	50% of eligible expenses incurred, after the orthodontia services deductible is satisfied

SPECIAL RESTRICTIONS FOR LATE ENROLLEES

If an Employee or a Dependent over five (5) years of age is enrolled late (see "Late Enrollment" in the **Eligibility and Effective Dates** section), dental benefits for that individual are limited as follows:

during the first year of coverage, benefits are limited to those for Preventive Services, Basic Services and dental services necessitated by an Accidental Injury; and

DENTAL BENEFIT SUMMARY, CONTINUED

Major Services are not Eligible Expenses until the individual has been covered under the Plan for twelve (12) consecutive months; and

Orthodontic benefits are not available until a Dependent child has been covered under the Plan for two (2) consecutive years.

ELIGIBLE DENTAL CARE EXPENSES

A charge for any of the services or supplies listed below will be considered eligible if it is reasonably necessary for the care of a Covered Person's dental condition. To be considered reasonably necessary, the service or supply must be ordered by a dentist licensed by his or her state of practice and must be commonly and customarily recognized as appropriate in the treatment of the patient's diagnosed dental condition. The service or supply must not be educational or experimental in nature, nor provided primarily for the purpose of dental or other research. In addition to the above definition of the term "Eligible Expense", the following terms have the defined meaning as used in this Plan:

a "dental hygienist" means a person who is licensed by the state in which services are performed to practice dental hygiene and who works under the supervision and direction of a dentist; and

a "dentist" means a person licensed by his state of practice to practice dentistry and render dental care services within the scope of his license for treatments covered under the Plan.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

Preventive Services

Oral Examinations and Prophylaxis - Limited to 2 per calendar year.

Sealants – Limited to children under age 14, and to one treatment per tooth per Lifetime. Coverage is further limited to application on the occlusal (biting) surface of permanent molars only, and only if such molars are free of decay or prior restoration.

Topical Fluoride Applications - Limited to children under age 19.

X-rays - Limited to 4 films per six-month period for bitewing x-rays, and once every 36 months for full mouth x-rays. All other x-rays required for diagnosis or treatment of a dental condition will be eligible without frequency limitations. X-rays related to orthodontia services are payable under Orthodontia Services only.

Basic Services

Anesthesia - General anesthesia, including IV sedation, when administered in connection with oral or maxillofacial surgery.

NOTE: Separate charges for pre-medication, local anesthesia, or analgesia are not covered. Such services should be included in the cost of the procedure itself.

DENTAL BENEFIT SUMMARY, CONTINUED

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulp vitality tests, pulpotomy, apicoectomy and retrograde filling.

Extraction - see "Oral Surgery"

Fillings, Non-Precious - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

NOTE: Excess charges for tooth-colored restorations are not covered for posterior teeth. See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions**.

Injections - Injection of antibiotic drugs.

Myofunctional Therapy - Muscle training therapy to correct or control harmful habits.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth and other oral surgeries including biopsies of oral tissue and grafting of tissues from outside the mouth to oral tissues.

Palliatives - Emergency treatment for the relief of dental pain, but limited to emergency treatment of an abscess or infection of a tooth or supporting structures.

Pathology - Diagnostic laboratory services performed to assist in the diagnosis of oral disease.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing.

Repairs & Relines - Repair or re-cementing of crowns, inlays, bridgework or dentures.

Relining or Rebasement of Dentures – Limited to one service per 36-month period. Benefits are payable only when the relining or rebasing is performed more than six (6) months after placement.

Space Maintainers – Limited to Dependent Children under age 19. Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

Major Services

Crowns - A stainless steel, gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Inlays, Onlays, Porcelain Restorations, Etc. - An inlay, onlay or other gold or baked porcelain restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

Replacement of an inlay, onlay or other gold or porcelain restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable.

Prosthetics - Initial placement of a full or partial denture or bridge. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement. However, if the prosthetic includes replacement of a tooth which was missing before the individual was covered under the Plan, then no benefits will be provided unless:

such prosthetic also includes replacement of a tooth which was extracted after the individual's coverage effective date; or

DENTAL BENEFIT SUMMARY, CONTINUED

the individual has been covered under the Plan for at least twenty-four (24) consecutive months, including time covered under the Employer's plan of dental coverage which this Plan replaces.

Replacement of, or addition of teeth to, an existing full or partial denture or bridgework, but only if:

the replacement or addition of teeth is required to replace one (1) or more teeth extracted while the individual was covered;

the existing denture or bridgework cannot be made serviceable and is at least five (5) years old; or

the existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Orthodontia Services

Limited to Dependent Children only.

Services or supplies provided for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, x-rays and other diagnostic services;

oral surgery and extractions;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

Orthodontia benefits will begin upon submission of proof that the orthodontia treatment program has begun. Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is shown in the "Plan Maximums" in the **Dental Benefit Summary**. This maximum applies to the entire period(s) a person is covered under the Plan.

NOTE: Charges for the replacement or repair of an orthodontic appliance are not covered.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits are payable under the Plan for the following expenses.

Appliances - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances.

Congenital or Developmental Conditions - Treatment of congenital (hereditary) or developmental (following birth) malformations, but only to the extent that coverage is not provided under the City's medical coverage.

Consultations - Services provided or received for consultation purposes.

Cosmetic Dentistry - Treatment rendered primarily for cosmetic purposes, except for covered orthodontia services.

NOTE: Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or a tooth-colored restoration is not covered on a tooth posterior to the second bicuspid but will be considered "cosmetic". The maximum allowance will be the allowance for the least costly restoration which will provide a functional result.

DENTAL BENEFIT SUMMARY, CONTINUED

Customized Prosthetics - Precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Charges or Excess Care - Charges in excess of the Usual, Customary and Reasonable fees.

Services which exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental Procedures - Services which are considered experimental or which are not approved by the American Dental Association.

Hospital Expenses

Implants - Implants (materials implanted into or on bone or soft tissue) or the removal of implants.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

Medical Expenses - Any dental services to the extent to which coverage is provided under any medical or other coverages offered by the Plan Sponsor.

Missing Permanent Tooth - Replacement of a permanent tooth that was lost or extracted before the individual's effective date of coverage under the Plan.

Non-Professional Care - Services rendered by someone other than:

a dentist (D.D.S. or D.M.D.);

a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

a Physician furnishing dental services for which he is licensed.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

increasing the vertical dimension;

replacing or stabilizing tooth structure lost by attrition;

realignment of teeth;

gnathological recording or bite registration or bite analysis;

occlusal equilibration.

Oral Hygiene Counseling, Etc. - Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks, and mouthwashes.

Prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.

Personalization or Characterization of Dentures

Prior to Effective Date / After Termination Date - Courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date.

Splinting - Appliances and restorations for splinting teeth, including double abutments for prosthetics.

Temporary Restorations and Appliances - Excess charges for temporary restorations and appliances. The Eligible Expenses for the permanent restoration or appliance will be the maximum covered charge.

TMJ / Jaw Joint Treatment - Any services or supplies to treat temporomandibular joint (TMJ) dysfunction or pain syndromes.

*- (See also **General Exclusions** section) -*

LIMITATION OF DENTAL COVERAGE/PRE-TREATMENT ESTIMATE OF BENEFITS

The Plan will consider eligible expenses based on the appropriate treatment necessary to eliminate oral disease or to replace missing teeth. For example, if a tooth can effectively be restored with amalgam filling but a Covered Person elects to crown the tooth, the Plan will consider its benefits based on the Usual, Reasonable and Customary limit for the amalgam filling. The Covered Person will be responsible for paying the remaining charges.

In addition, temporary services will be considered as an integral part of the final service rather than as a separate service. The allowance for both the temporary and permanent procedures may not exceed the Usual, Reasonable and Customary limit of the permanent procedure.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

If extensive dental work is needed (i.e., where the proposed treatment cost exceeds \$300), the Plan Sponsor recommends that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained. A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimate.

NOTE: A PRE-TREATMENT ESTIMATE IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME THE SERVICES ARE ACTUALLY INCURRED.

GENERAL EXCLUSIONS

The following exclusions apply to all benefits. No benefits will be payable for:

Criminal Activities - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies not specifically listed as Eligible Expenses.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).

Treatment provided through a medical department, clinic or similar facility furnished or maintained by the Employer.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country. However, this exclusion will apply to US military active-duty service in compliance with the City's guidelines.

Work-Related Conditions - Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, or any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides health care benefits or services:

group, blanket or franchise coverage provided through HMOs and other prepayment group or individual practice plans;

governmental programs, as permitted by law;

any coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans; or

any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits which would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The coverages of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is Medically Necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the negotiated fees shall be the Allowable Expense for This Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

Claim Determination Period - A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary", the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent - The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married or are not separated (whether or not they have ever been married), or (2) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual

COORDINATION OF BENEFITS, continued

knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Claimant for the longer period of time will be determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SUBROGATION AND REIMBURSEMENT, THIRD PARTY RECOVERY

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 Covered Persons or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") 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").

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

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary 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 Plan Beneficiary 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 Plan Beneficiary is entitled, regardless of how classified or characterized.

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

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

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

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

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

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. The Plan's benefits shall be excess to:

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

Wrongful Death Claims

In the event that the Plan Beneficiary 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 Plan Beneficiary's obligation:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the sickness, disease, disability or injury, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

Offset

Failure by the Plan Beneficiary 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 Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary 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.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

To participate in the health coverages of the Plan as an "Employee" an individual must be in full-time active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel), regularly scheduled to work at least forty (40) hours per week, and receiving regular earnings from the Employer.

Independent contractors, contract workers, temporary employee, seasonal and casual employees and leased employees are not eligible to participate in the Plan.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

NOTE: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

An eligible active Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first of the month following three (3) months of active employment. However, if an Employee is not in active employment on the date his coverage is to be effective, then his coverage will not be effective until he returns to active employment.

An Employee must enroll for Plan coverage within thirty-one (31) days after completion of the waiting period. If he does not enroll, his coverage can become effective later only in accordance with the "Annual Enrollment" provision.

Employees who elect not to enroll must complete a waiver of coverage form. The form must be submitted to the Employer within the 31-day enrollment period.

Eligibility Requirements - Dependents

An eligible Dependent of an Employee is:

a spouse of the opposite sex. The marriage must meet all requirements of a valid marriage contract in the state of marriage. A common law spouse will be eligible in a state that recognizes a common-law marriage but a notarized "Affidavit of Common-Law Marriage" will be required;

an unmarried child until the month in which the child attains age 19, who: (a) is financially dependent upon the Employee or the Employee's spouse for support and maintenance, or (b) resides with the Employee or has the Employee's home as the chief place of residence and the Employee and child have a parent-child relationship. For these purposes a "child" will include:

- a natural child, unless adopted by a stepparent;
- a stepchild;
- a child placed under the legal guardianship of the Employee or the Employee's spouse;
- a foster child who is living in a regular parent-child relationship with the Employee and with the expectation that the Employee will continue to rear the child into adulthood. To establish the child's eligibility, the Employee must submit evidence of a bonafide foster child relationship, identifying the foster child by name and setting forth all the relevant aspects of the relationship. A child placed in a home by a welfare agency which obtains control of and provides for maintenance of the child is not an eligible dependent;
- a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial

ELIGIBILITY AND EFFECTIVE DATES, continued

support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun;

- notwithstanding any main support and care requirements, a child for whom the Employee or covered Dependent spouse is required to provide coverage due divorce decree or court order, including a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a));

an unmarried student age 19 or over and until the end of the month in which the child reaches age 25, if such child meets the above Dependent child eligibility requirements except for age, and is in full-time school attendance at a vocational trade school, accredited high school, college or university.

"Full-time school attendance" at a college or university means enrolled for at least 12 units per semester. In other schools, "full-time" is as defined by the educational institution.

Cessation of full-time school attendance will terminate the student's eligibility, except that: (a) if cessation is due to school vacation or semester break, Dependent eligibility will cease on the date the school reconvenes if attendance does not resume, (b) if cessation is due to graduation, eligibility will cease at the end of the month following graduation, or (c) if cessation is due to disability that prevents the student's full-time attendance, eligibility will terminate on the first day of the school's next regular session following the date established by a Physician's written statement to the Contract Administrator that the student is capable of full-time school attendance.

NOTE: Any grandchild covered prior to January 1, 2002, under the City of Tyler's health plan will continue to be eligible. The Plan may require proof (such as a copy of the Employee's income tax form, court order, legal adoption or legal guardianship appears) that a spouse or child qualifies as a Dependent under the Plan.

An eligible Dependent does not include:

- a spouse following legal separation or a final decree of dissolution or divorce;
- a same-sex domestic partner;
- any person who is on active duty in a military service;
- any person who is eligible and has enrolled as an Employee under the Plan;
- any person who is covered as a Dependent of another Employee under the Plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

NOTE: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date and, except as noted, coverage will be effective on the date of eligibility. Otherwise, a Dependent can be enrolled only in accordance with the "Annual Enrollment" provision.

An eligible Dependent may be added to the Plan and will not be subject to the Annual Enrollment requirements if the Employee or covered Dependent spouse has been ordered to provide coverage in accordance with a Qualified Medical Child Support Order as required by ERISA section 609.

NOTES: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date. Also, if a Dependent (other than a newborn child) is hospitalized or totally disabled on the date his coverage is to be effective, then coverage will be delayed until the Dependent is no longer disabled or hospitalized. For these purposes, "totally disabled" means a physical state, resulting from illness or injury, which wholly prevents the individual from performing the normal activities of a person of like age and sex in good health.

Special Enrollment Rights

An individual who enrolls in accordance with this "Special Enrollment Rights" provision is not a "late enrollee" as that term applies to the pre-existing condition limitations.

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

he was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted;
- loss of Medicaid coverage.

and the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that

begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the date of marriage;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Change in Status, Cost or Coverage – An Employee will be permitted to make Plan election changes when such changes are consistent with and made concurrently with changes allowed under the Plan Sponsor's Section 125 cafeteria plan due to a qualified change as permitted under Federal law. The effective date of the Plan changes will be concurrent with the effective date of the cafeteria plan changes, unless an earlier effective date would be allowed under the terms of one of the other subsections of this "Special Enrollment Rights" provision.

Newborn Children - Limited Automatic 31-Day Benefit Period

An Employee's newborn child will be eligible for benefits for Eligible Expenses which are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

NOTE: During the limited 31-day benefit period, a newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Annual Enrollment

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Annual Enrollment period which will be held in the month of December of each year. Plan coverage will be effective as of the next following January 1.

Actively-at-Work / Non-Confinement Requirements

If an Employee is totally disabled and is not in active employment on the date coverage would otherwise become effective, the Employee's coverage will not become effective until the date that he/she returns to active employment.

In order for coverage to become effective on the date it is scheduled, a Dependent must not be totally disabled,

confined to an institution, or confined at home under medical care. If the Dependent is so disabled or confined, then the Dependent's coverage will not go into effect until the Dependent is able to carry on the normal duties or activities of a person in good health who is the same sex and approximate age. Further, a Dependent's coverage will not become effective until the Employee's coverage has also become effective.

For these above purposes, "totally disabled" means an Employee or unemployed Dependent is unable to perform all of the substantial and material duties and functions of his occupation or any other gainful occupation in which he can earn substantially the same compensation earned prior to disability. For an unemployed Dependent, it means his complete inability to carry on all of the normal duties or activities of a person in good health who is the same sex and approximate age.

NOTE: This provision will NOT apply to: (1) a Dependent child born while the Employee is covered under the Plan and who would otherwise have coverage effective on the date of birth, (2) an adopted child of the Employee as defined by law, whether or not the adoption has become final, (3) a COBRA transferee, or (4) an FMLA leave.

Reinstatement / Rehire

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any Dependents who were covered at the point contributions ceased). However, Employee must request that coverage be restored before his family or medical leave expires. No waiting period requirement will be applied and the pre-existing condition limitation will apply only to the extent it may have applied on the date coverage terminated.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

If an Employee or Dependent returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the **COBRA Continuation Coverage**, such person will be reinstated to active status and will have uninterrupted coverage under the Plan. That is, a new waiting period requirement will not be applied and the Plan's pre-existing condition limits will apply to the newly eligible person's coverage only to the extent they may have applied upon discontinuance of COBRA coverage.

NOTE: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Adjustments for Prior Plan Sponsor Coverage

If these health coverages are an immediate replacement of prior coverage(s) offered by the Plan Sponsor, they are intended to replace the prior coverage(s). Except to the extent that benefits are expressly modified, any deductibles satisfied or benefits paid with respect to such Covered Persons under the prior coverage(s) will be deemed to be Deductibles satisfied or benefits paid under the Plan Document for a person who was covered under the prior coverage(s) on the day of discontinuance and who is eligible as an active enrollee or a COBRA enrollee under the Plan Document on its effective date. Any contiguous periods a Covered Person was covered under prior coverage(s) of the Plan Sponsor will be deemed to be time covered under the Plan Document.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under the Plan (including a retired Employee's coverage, as applicable) will terminate upon the earliest of the following:

termination of the Plan;

termination of participation in the Plan by the Employee;

on the date on which the Employee ceases to qualify as an eligible Employee;

on the date a retired Employee becomes eligible for Medicare;

the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information;

the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the last day of the month in which the covered active Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision;

the date the Employee dies.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

Dependent Coverage Termination

A Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight on the last day of the month in which Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost) or the date the Employee elects to terminate Dependent coverage. However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

- (See **COBRA Continuation Coverage**) -

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children

If an already covered Dependent child attains the age which would otherwise terminate his status as a "Dependent," and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability which results from injury, accident, congenital defect or sickness;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis and are as outlined in the Employer's personnel policies or other Employee communications. Such documents are incorporated by reference.

Except as noted, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

the date specified in the Employer's written personnel policies or Employee communications;

the end of the period for which the last contribution was paid, if such contribution is required;

the date of termination of this Plan.

NOTE: To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

EXTENSION OF COVERAGE PROVISIONS, continued

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent 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 (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered servicemember. A "covered servicemember" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months (or up to 24 months for elections made on or after December 10, 2004), or the duration of active military service, whichever is shorter. The Employee must pay the cost of coverage. The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost if the military leave is less than 31 days.

Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

The Employee who is ordered to active military service (and that Employee's eligible Dependent(s)) are considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the

EXTENSION OF COVERAGE PROVISIONS, continued

Plan in accordance with the above stipulations.

Extension of Coverage for Retirees Not Eligible for Medicare

If an Employee is working for the City at the time of his retirement and is not eligible for Medicare (i.e. he is a "Non-Medicare Retiree"), then the Non-Medicare Retiree is eligible to continue Plan coverages for himself and his eligible Dependents. Retiree must inform the Staff Services Department not later than the date of his retirement if coverage is to be continued. Later election of extended coverage will not be permitted.

An Employee who elects to remain in the Plan as a Non-Medicare Retiree must continue to pay his portion of the cost of coverage and abide by other conditions of the Plan. Employees hired after January 1, 1997 must pay the full cost of coverage.

Except as noted, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

the date specified in the City's written policies and procedures;

the end of the period for which the last contribution was paid, if such contribution is required;

the date the retiree is eligible for Medicare, except that continued coverage will be permitted under the prescription coverage offered by the City;

the date of termination of this Plan.

More information about this extension of coverage allowance is included in the City's policies and procedures.

NOTE: Only those individuals who were covered under the Plan on the day immediately prior to the Employee's retirement will be eligible for continued Plan coverage under the terms of this provision.

- (See *COBRA Continuation Coverage*) -

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect. In accordance with IRS Revenue Ruling 2004-22, it is not the Plan's intent to recognize a terminated Employee's Medicare entitlement as a second Qualifying Event for a spouse or child who is covered under the Plan as a COBRA Qualified Beneficiary;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual

to whom a Qualifying Event has not occurred).

Notification – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election, etc.), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

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

Open enrollment rights which allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified

Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

the cost previously charged was less than the maximum permitted by law;

the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments which are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

Also, COBRA coverage will run concurrently with medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). That is, if an Employee on military leave continues coverage under USERRA, equivalent months of COBRA entitlement will be exhausted, unless there was another Qualifying Event.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

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

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the

individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's pre-existing condition exclusion provision.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(b), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number. A claim must be in English. Any request for a benefit determination that is in a language other than English will not be considered a claim for the purposes of the Plan. The claimant is responsible for any and all costs associated with translation. Such translation must be obtained by the claimant prior to submission of a request for benefit determination.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the Utilization Management Program section for that information.

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within 365 days after charges are incurred. Upon termination of the Plan, final claims must be received within ninety (90) day of termination.

A Post-Service Claim should be submitted to:

**HealthFirst - Third Party Administrators
P. O. Box 130217
Tyler, TX 75713**

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

It is the Claimant's obligation:

- 1) to cooperate with the Plan, or any representatives of the Plan, in handling claims;
- 2) to provide the Plan with pertinent information regarding the sickness, disease, disability or injury and any other requested additional information relating to the claim;
- 3) to take such action and provide such information as the Plan may require to process a claim.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for

filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond, etc.). It is the Claimant's obligation to:

- a) cooperate with the Plan, or any representatives of the Plan, in handling claims;
- b) provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, and any other requested additional information relating to the claim;
- c) take such action and provide such information as the Plan may require to process a claim.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Urgent Claim - defined below</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p>	<p>Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. Claimant will have a reasonable period of time, but not less than 48 hours, to provide the required information to complete the claim.</p> <p>Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information. Oral notice can be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination. Oral notice can be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.</p> <p>See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.</p>
<p>An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. All necessary information, including the Plan's handling of an appeal, shall be transmitted between the Plan and the Claimant by telephone, fax or other available and similarly expeditious methods.</p> <p>Whether a claim is urgent will generally be decided by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician familiar with the Claimant's condition decides that the claim involves urgent care, the Plan must defer to the Physician's judgment.</p> <p>NOTE: The benefit determination time frame stated above shall begin at a time a claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.</p> <p>Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, considering the urgency of the medical situation.</p>	

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Concurrent Care Claim - defined below</p> <p>Plan Wants to Reduce or Terminate Already Approved Care</p> <p>Claimant Requests Extension for Urgent Care</p> <p>A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.</p>	<p>Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.</p> <p>Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.</p>
<p>Non-Urgent Claim</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p> <p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.</p> <p>In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.</p>	<p>Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification. Claimant has at least 45 days from receipt of such notice to provide the required information.</p> <p>Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below</p> <p>Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.</p> <p>See "Appeal Procedures" subsection.</p> <p>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</p>

"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant – see definition of "full notice" below. Claimant has at least 45 days to provide required information.
Plan Receives <u>Completing</u> Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
<p>"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.</p>	
<p>In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.</p>	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits;

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and

copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: The Plan requires two (2) levels of mandatory appeal.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

identification of any medical or vocational experts whose advice was obtained in connection with the claim denial;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - An injury resulting directly and independently of all other causes and which requires care by a covered provider within thirty (30) days after the accident.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.

Claimant - Any Covered Person for whom a claim is submitted for benefits under the Plan.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **Continuation of Coverage Option (COBRA)** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Dentist - An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the operating scope of his license.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense which is (1) covered by a specific benefit provision of the Plan Document and (2) incurred while the person is covered by the Plan Document.

Employee - see **Eligibility and Effective Dates** section

Employer - An Employer participating in the Plan.

Fiduciary - A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Plan - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Usual, Customary and Reasonable - A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of dental conditions comparable in severity and nature to the dental condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

GENERAL PLAN INFORMATION

Name of Plan:

City of Tyler Dental Plan

Plan Sponsor / Plan Administrator:

City of Tyler, Texas
212 N. Bonner
Tyler, TX 75702
(903) 531-1112

Participating Employer(s):

City of Tyler, Texas

Plan Sponsor ID Number (EIN):

75-6000697

Plan Number:

501

Plan Year:

January 1 through December 31

Plan Benefits:

Medical and Prescription Drug Program benefits

Named Fiduciary:

City of Tyler, Texas
212 N. Bonner
Tyler, TX 75702
(903) 531-1112

(See also definition of "Fiduciary")

Agent for Service of Legal Process:

City Attorney
City of Tyler, Texas
212 N. Bonner
Tyler, TX 75702

(Legal process may be served upon the Plan Administrator or a Fiduciary)

Contract Administrator:

Mailing Address:

Street Address:

Phone:

HealthFirst - Third Party Administrators

P. O. Box 130217
Tyler, TX 75713
821 E.S.E., Loop 323, Suite 200
Tyler, TX 75701
(903) 581-2600

FUNDING - SOURCES AND USES

Employee & Employer Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (NonCOBRA) enrollees, except in special circumstances where a greater cost is allowed

by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer. If Plan benefits are part of an Employer-sponsored cafeteria plan under Section 125 of the Internal Revenue Code, such coverage costs may be deducted on a pre-tax basis.

Self-Funded Benefits

Contributions will be used to provide the non-insured benefits of the Plan.

Administration Expenses

Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

Taxes

Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)

Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the exclusive right to, without the consent of any participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates - Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Plan Document, the Plan Document will prevail.

Entire Contract

The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such

guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Plan Document will not affect the other provisions and the Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator or the delegated Contract Administrator shall make determinations regarding Plan Benefits.

Privacy Rules & Intent to Comply

On and after April 14, 2003, (or effective April 14, 2004 if the Plan's premium equivalent is less than \$5 million annually), the Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA). See the section entitled **Privacy Rules** for more information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Termination for Cause

Coverage will terminate for an entire family unit (or a COBRA Qualified Beneficiary) in certain situations. Except as specified below, any termination will be effective immediately upon receipt by the Employee (or the COBRA Qualified Beneficiary) of a written notice from the Plan Sponsor. Any written notice will specify the reason for

termination/rescission, the facts supporting such action, the effective date of the termination/rescission, and a notice that no expenses incurred after such date will be covered by the Plan. Coverage will end:

if a Covered Person makes a material misstatement in an application for initial coverage or a change in coverage with the intent to deceive. Coverage will be rescinded back to the original effective date and no coverage will ever have been in effect. A material misstatement will be deemed valid after two (2) years of continuous coverage after the making of the material misstatement;

if a Covered Person permits any other person to use of any evidence of coverage in their name (or the Employee's name in the case of a Dependent). This does not apply to an Employee with respect to his covered Dependents;

a Covered Person, singularly or in collusion with others, commits, attempt to commit, aids or abets claim fraud.

Titles or Headings

Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

Type of Plan

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

PRIVACY RULES

On and after April 14, 2003 (or effective April 14, 2004 if the Plan's premium equivalent is less than \$5 million annually), the Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of "protected health information" (herein also "PHI") of Plan participants.

PHI is individually identifiable health information created or received by the Plan that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entities that may assist in the operation of the Plan.

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining his authorization, only if the use or disclosure is to carry out payment of benefits or for health care operations or if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities). For these purposes: "payment" means activities associated with eligibility and coverage determinations, coordination of benefits, claims management, utilization review and other related health plan administrative activities; "health care operations" means other health plan administrative tasks such as quality improvement activities, activities related to obtaining health insurance policies or stop loss insurance, and legal and auditing functions.

In order to comply with the Privacy Rules, the Plan Sponsor agrees to:

receive PHI from the Plan only when the entity providing PHI has received written certification that the Plan Document has been amended;

adopt privacy policies. Such policies will include the uses and disclosures the Plan will make with regard to protected health information of Plan participants and when and to whom such information (PHI) will or will not be disclosed. Those policies are incorporated into the Plan Document by reference;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions such as quality assurance, claims processing, auditing, monitoring and management of carve-out plans (such as vision or dental);

even when health information is used for payment and Plan operations, only the minimum necessary information will be requested and obtained;

not use or disclose PHI for employment-related purposes or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

not use or further disclose protected health information (PHI) other than as permitted or required by the Plan Document and by law;

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

make Plan participants' PHI available to them upon request in accordance with the Privacy Rules;

make Plan Participants' PHI available to them for amendment and correction in accordance with the Privacy Rules;

make PHI available as required to provide an accounting of non-routine disclosures;

make the Plan Sponsor's internal practices, books, and records related to uses and disclosure of PHI available to the Health and Human Services department for purposes of compliance enforcement;

when feasible, return or destroy all PHI received from the Plan once it is no longer needed;

provide for adequate separation of the Plan and the Plan Sponsor (i.e., create "firewalls"), by:

- identifying which specific employees, classes of employees or others under the control of the Plan Sponsor will have access to PHI and restrict that access to Plan administration purposes, and
- establishing a mechanism for resolving issues of noncompliance by the individuals who have access.

ensure that any agents or subcontractors of the Plan who receive PHI will abide by the same restrictions and conditions that apply to the Plan Sponsor;

train employees in privacy protection requirements and appoint a privacy official responsible for such protections;

provide sanctions for those employees who violate the policies;

establish grievance procedures for individuals who believe their privacy rights have been violated;

adopt (or assure that the component operating the Plan adopts) the data transmission standards and code sets as prescribed by the Health and Human Services (HHS) to promote administrative simplification and reduce administrative costs.

Required Separation between the Plan and the Plan Sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan Sponsor who may be given access to individuals' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan:

[List]

This list reflects the employees, classes of employees or other workforce members of the Plan Sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan Sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the provisions of this Amendment.

The Plan Sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

NOTE: The Privacy Rules requirements do not apply if the Employer is provided only with "summary health information" and the information is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is claims-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient identifying numbers or characteristics.

SECURITY RULES

On and after April 20, 2005 (or effective April 20, 2006 if the Plan's premium equivalent is less than \$5 million annually), the Plan will comply with the security regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160, 162 and 165 (the "Security Regulations").

Definitions

Electronic Protected Health Information has the meaning set forth in 45 C.F.R. §160.103, as amended from time to time, and generally means the protected health information that is transmitted or maintained in any electronic media.

Plan means the City of Tyler Medical Plan

Plan Documents mean the Plan's governing documents and instruments (i.e., the documents under which the Plan was established and is maintained), including but not limited to the City of Tyler Medical Plan Plan Document.

Plan Sponsor means City of Tyler.

Security Incidents has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request.

ADOPTION OF THE PLAN DOCUMENT

Adoption

The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of Date.

City of Tyler

By:



Title:

CITY MANAGER

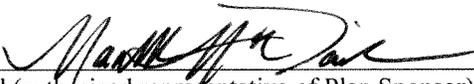
PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

**HealthFirst
Third Party Administrators
821 E.S.E. Loop 323, Suite 200
Tyler, TX 75701**

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Plan Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator:



Signed (authorized representative of Plan Sponsor) 1/1/10
Date

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