

**The Chatham County
Health & Welfare Benefits Policy**

Effective July 1, 2023

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ARTICLE I

Introduction

1.1 Effective Date

The Chatham County Health & Welfare Benefits Policy (the “Plan”) is effective July 1, 2023.

1.2 Purpose of Plan

The purpose of the Plan is to provide certain health and welfare benefits to Eligible Employees and/or Eligible Retirees of any Participating Employer. The Plan is to be maintained for the exclusive benefit of Eligible Employees, Eligible Retirees, Spouses, and their covered Dependents.

1.3 Plan Status

The Plan intends that certain of the Benefits provided under the Plan will be eligible for exclusion from gross income under the Code. In this respect, the Plan (including, but not limited to, the Group Legal Plan) shall be treated as a single welfare benefit plan within the meaning of Section 3(1) of ERISA; the Life Insurance Plan is intended to satisfy the requirements for a group term life insurance plan within the meaning of Code Section 79; and the AD&D Insurance Plan, the Long Term Disability Insurance Plan, the Vision Plan, the Dental Plan, the Voluntary Benefits Plan (as pertains to cancer, hospital confinement, short-term disability, critical illness, whole life, universal life, and accident insurance), the Employee Assistance Plan, the Wellness Plan, and the Medical/Prescription Drug Plan are intended to constitute an accident and health plan (within the meaning of Code Sections 105 and 106) and to satisfy the requirements of Code Section 101 (for certain death benefits).

In addition, the Plan is intended to constitute a cafeteria plan in accordance with the requirements of Code Section 125 and the regulations thereunder and provide for reduction of Compensation, in accordance with the terms of Code Sections 105, 106 and 125, and to pay for certain Benefits offered under the Plan’s Benefit Package Options, and provide for certain Health Care Flexible Spending Account Benefits in accordance with the terms of Code Sections 105(h) and 125 and Dependent Care Assistance Flexible Spending Account Benefits in accordance with the provisions of Code Sections 125 and 129.

Furthermore, the Plan is intended to satisfy the applicable requirements of the Code, COBRA, HIPAA, ADA, FMLA, USERRA, GINA, MHPAEA, PPACA and any other applicable law, including regulations and rulings issued pursuant to any such laws to the extent applicable to one or more Related Documents.

Lastly, the Plan is intended to qualify as a “governmental plan,” within the meaning of Section 3(32) of ERISA. As such, the Plan is exempt from the requirements of ERISA

pursuant to Section 4(b)(1) of ERISA. Nevertheless, as a matter of convenience and ease of administration of the Plan, this document may include references to certain provisions of ERISA and the Plan may choose to voluntarily comply with them. Such voluntary compliance is not meant to imply that the Plan or the County are subject in any way to ERISA.

1.4 Related Documents

The Plan includes and encompasses each of the individual plans, programs, insurance contracts, and benefit components that are listed in Appendix B, and the terms of such Related Documents are hereby incorporated into the Plan by reference. The Plan, together with the Related Documents, constitutes the written Plan document.

ARTICLE II

Definitions

The following words and phrases, as used in the Plan, shall have the meanings set forth below in this Article II unless a clearly different meaning is required by the context in which the word or phrase is used. In addition, use of the singular form of a word shall include the plural form, and vice versa, as appropriate. Any terms that are used or separately defined in any Related Document shall have the meaning set forth in such Related Document, as applicable.

2.1 ADA

ADA shall mean the Americans with Disabilities Act of 1990, as amended from time to time. Reference to any section or subsection of the ADA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.2 Adjustment Date

Adjustment Date shall mean the date or dates chosen by the Plan Administrator on which the Participant's Health Care Flexible Spending Account and/or the Dependent Care Assistance Flexible Spending Account is increased by the Participant's reduction of Compensation and reduced by payments made from such account(s).

2.3 Benefit Package Option

Benefit Package Option shall mean a qualified benefit under Code Section 125(f) that is offered under the Plan, including an option for coverage under the Medical/Prescription Drug, the Vision Plan, the Dental Plan, the Wellness Plan, the Life/AD&D Insurance Plan (but shall not include dependent life insurance), the Voluntary Benefits Plan (but shall not include the whole or universal life insurance), the Employee Assistance Plan, the Long Term Disability Insurance Plan, the Dependent Care Assistance Flexible Spending Account and the Health Care Flexible Spending Account. The Plan also includes a Group Legal Benefit Package Option.

2.4 Benefits

Benefits shall mean the benefits provided to Participants under this Plan and any Related Documents, as listed in the schedule of benefits for such Related Documents or in one or more other written documents approved by the Plan Administrator or the Board, with respect to such Related Documents.

2.5 Board

Board shall mean the Board of Commissioners of Chatham County.

2.6 CFR

CFR shall mean the Code of Federal Regulations.

2.7 Change in Status

Change in Status shall mean, unless otherwise set forth in an applicable Related Document, any of the following situations in which a Participant may make an enrollment election change at a time other than either during the Plan's Open Enrollment Period or when the Participant first enrolls in the Plan:

- (a) Events that change a Participant's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.
- (b) Events that change a Participant's number of Dependents, including the following: birth; death; adoption, placement for adoption; and an award of legal guardianship or legal custody.
- (c) Any of the following events that change the employment status of the Participant, his or her Spouse, or a Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if, with respect to the Participant, his or her Spouse, or a Dependent, the eligibility conditions of the Plan or Benefit Package Options of a Participating Employer or the eligibility conditions of a benefit plan of the employer of the Spouse or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment status under this paragraph.
- (d) Events that cause a Dependent to satisfy or cease to satisfy the eligibility requirements of any Benefit Package Option on account of attainment of age, student status, or any similar circumstance.
- (e) A change in the place of residence of the Participant, Spouse, or Dependent such that the Participant, Spouse or Dependent is no longer located within the service area of his Benefit plan.
- (f) A judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order (QMCSO) as defined in Section 609 of ERISA) that requires accident or health coverage for the Participant's child or for a foster child who is a Dependent of the Participant. The Plan shall change the Participant's election to provide coverage for the child if the order requires coverage for the child under one or more of the Benefit Package Options; or permit the Participant to make an election change to cancel coverage for the child if the order requires the Spouse, former Spouse, or

other individual to provide coverage for the child and that coverage is, in fact, provided.

- (g) Events that cause a Participant, Spouse, or Dependent who is enrolled in any of the Benefit Package Options to become entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare or Medicaid, other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The Plan shall permit the Participant to make a prospective election change to cancel or reduce coverage of that Participant, Spouse, or Dependent under one or more of the Benefit Package Options. In addition, if an Eligible Employee, Spouse, or Dependent who has been entitled to such coverage under Medicare or Medicaid loses eligibility for such coverage, the Plan shall permit the Eligible Employee to make a prospective election to commence or increase coverage of that Employee, Spouse, or Dependent under one or more of the Benefit Package Options.
- (h) Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

2.8 Claims Administrator

Claims Administrator shall mean the entity providing services to the County in connection with the operation of the Plans including the process and payment of claims for benefits under the Plans.

2.9 COBRA

COBRA shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Reference to any section or subsection of COBRA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.10 Code

Code shall mean the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.11 County

County shall mean Chatham County, Georgia Government.

2.12 Compensation

Compensation shall mean an Employee's wages, salaries, and other amounts received for personal services actually rendered during the Plan Year in the course of employment with a Participating Employer to the extent that the amounts are includable in gross income (including, but not limited to, commissions paid and bonuses) and prior to any reductions made under this Plan or any other plan allowing for reduction in Compensation.

2.13 Coverage Period

Coverage Period shall mean the effective period of coverage for Benefits under the Plan, which shall be the Plan Year for all Benefits under the Plan, including the Coverage Period for the Health Care Flexible Spending Account Plan and the Dependent Care Assistance Flexible Spending Account Plan which shall be the period from January 1 to December 31.

2.14 Dental Plan

Dental Plan shall mean the dental benefits provided under the Plan and described in the applicable Related Document.

2.15 Dependent

Dependent shall mean:

- (a) The legal Spouse of a Plan Participant;
- (b) Any child of the Participant. Eligibility as a dependent child ends on December 31, after their 26th birthday for vision, dental and health plans. For all other plans, eligibility is defined by the applicable Related Document.
- (c) Any unmarried child of a Participant who is physically or mentally incapable of self-support, regardless of the child's age, provided the child became physically or mentally incapable of self-support before reaching December 31, after their 26th birthday. Proof of incapacity must be received by the Employer within 31 days after coverage would otherwise terminate. Approval for continuation of benefit is subject to underwriting approval from the applicable insurance carrier. Additional proof of disability may be required from time to time thereafter.

For purposes of this Section, "child" means a natural child, a legally adopted child (or a child placed for adoption) if the child is under eighteen years of age at the time of the adoption (or placement for adoption), a stepchild, and a child for whom legal guardianship or legal custody has been awarded.

Notwithstanding the preceding, "Dependent" does not include any person (other than the Participant's Spouse or a child of the Participant described in Section 2.15(b)), who is not a citizen or national of the United States unless he or she is a resident of the United States, Canada or Mexico.

In addition, a Spouse or child (other than a child described in Section 2.15(b) on or after the effective date of that paragraph) will not qualify as an eligible dependent if he or she is on active duty in the armed forces of any country.

Except as provided in the next sentence and notwithstanding any other provision of this Plan, for purposes of the Plan, if a Dependent of an Employee (other than a Spouse of the Employee) is also an Employee, both Employees will be treated as Employees and neither will be treated as a Dependent under the Plan. Also, if both parents of a Dependent are Employees, only one parent may cover each eligible Dependent child.

In determining whether a person qualifies as a Dependent of the Participant under this Section, the Plan Administrator or the County shall require a Participant to provide adequate evidence that the person meets the applicable requirements of this Section, including but not limited to submission of required documents as described in the Chatham County Dependent Eligibility Verification form.

Notwithstanding the preceding or any other provision of this Plan to the contrary, for purposes of any dependent coverage offered as an insured benefit under any Benefit Package Option, if the insurance contract uses a different definition of dependent than the definition of Dependent that would otherwise apply under this Section, that definition will prevail and any person who would qualify as a dependent under that insurance contract will be treated as a Dependent under this Plan for purposes of that Benefit Package Option.

Notwithstanding the foregoing, health care Benefits will be provided in accordance with the applicable requirements of a QMCSO, even if the child does not satisfy the definition of Dependent.

2.16 Dependent Care Assistance Flexible Spending Account

Dependent Care Assistance Flexible Spending Account shall mean the balance posted to the nominal recordkeeping account of each Participant or Former Participant, consisting of any elective reductions of Compensation for the payment of Dependent Care Assistance Flexible Spending Account Benefits less any payment therefrom, in accordance with Article VI and the applicable Related Document.

2.17 Dependent Care Assistance Flexible Spending Account Benefits

Dependent Care Assistance Flexible Spending Account Benefits shall mean those expenses eligible for reimbursement as provided for by the Plan and which satisfy the criteria of eligible dependent care assistance expenses under Code Section 129.

2.18 Eligible Employee

Eligible Employee shall mean an Employee who is a member of a classification of Employees that has been designated by a Participating Employer as eligible to participate in the Plan, as set forth in the applicable Related Document.

2.19 Eligible Retiree

Eligible Retiree shall mean a Retiree, as defined in Section 2.48, who is a member of a classification of Retirees that has been designated by a Participating Employer as eligible to participate in retiree benefits under the Plan, as set forth in the applicable Related Document.

2.20 Employee

Employee shall mean any individual who is in the active employment of a Participating Employer on a regular full-time, or temporary full-time basis working at least forty (40) hours per week and, in the case of the Medical/Prescription Drug Plan, working at least thirty (30) hours per week. Employee shall also mean any individual working 30 hours per week, but said individual may be excluded from certain benefits in the benefit package option as described in Section 3.2

An individual shall be considered in the active employment of a Participating Employer with respect to any Plan Year if the relationship during such year between him or her and a Participating Employer is the legal relationship of employer and employee.

The term “Employee” shall not include any individual who is classified by a Participating Employer as an employee who is a member of a collective bargaining unit covered under a collective bargaining agreement (unless the terms of the collective bargaining agreement provide for benefits offered under this Plan to be covered), a part-time temporary employee, a sub-contractor, or an intern. In addition, if the Participating Employer is, or at any time becomes, a sole proprietorship, a partnership, a limited liability company (taxed for federal income tax purposes as a partnership), a limited liability partnership or a subchapter S corporation, sole proprietors, partners, limited liability company principals, limited liability partners and 2% shareholders (as defined in Code Section 1372(b)) may not participate in the Code Section 125 Compensation reduction feature of the Plan.

For purposes of determining eligibility under the Plan, the classification to which an individual is assigned by a Participating Employer shall be final and conclusive, regardless of whether a court or other entity subsequently finds that such individual should have been assigned to a different classification.

2.21 ERISA

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.22 FMLA

FMLA shall mean the federal Family and Medical Leave Act of 1993, as amended from time to time. Reference to any section or subsection of the FMLA includes reference to

any comparable or succeeding provisions of any legislation that amends, supplements or replaces such section or subsection.

2.23 GINA

GINA shall mean the Genetic Information Nondiscrimination Act of 2008.

2.24 Grandfathered Plan

Grandfathered Plan shall mean a Benefit Package Option offered under the Medical/Prescription Drug Plan, if any, that is a grandfathered plan for purposes of PPACA Section 1251 and any applicable regulations or other guidance issued pursuant to that Act, as determined by the Participating Employer.

2.25 Group Legal Plan

Group Legal Plan shall mean the group legal benefits provided under the Plan and described in the applicable Related Document.

2.26 Health Care Flexible Spending Account

Health Care Flexible Spending Account shall mean the balance posted to the nominal recordkeeping account of each Participant or Former Participant, consisting of any elective reductions of Compensation for the payment of Health Care Flexible Spending Account Benefits less any payment therefrom, in accordance with Article V and the applicable Related Document.

2.27 Health Care Flexible Spending Account Benefits

Health Care Flexible Spending Account Benefits shall mean health related expenditures that meet the definition of medical care under Code Section 213 (as permitted under Code Section 125 and applicable regulations), provided that (a) the Participant or other person incurring the expense is not reimbursed (or entitled to reimbursement) for the expense through insurance, any welfare benefit plan maintained by the Participating Employer or otherwise (other than under the Plan), or (b) the Participant has not taken and will not take the expense as a deduction on the Participant's federal income tax return for any year. Health Care Flexible Spending Account Benefits do not include any premiums paid for health coverage under any plan maintained by the Participating Employer or any other employer.

2.28 Highly Compensated Employee

Highly Compensated Employee shall mean an individual as described in Code Section 414(q).

2.29 Highly Compensated Individual

Highly Compensated Individual shall mean an individual as described in Code Section 125(e), except that with respect to the Medical Plan, Highly Compensated Individual shall mean an individual as described in Code Section 105(h).

2.30 HIPAA

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. Reference to any section or subsection of HIPAA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.31 Key Employee

Key Employee shall mean an individual as described in Code Section 416(i)(1).

2.32 Life/AD&D Insurance Plan

Life/AD&D Insurance Plan shall mean the group term life insurance and accidental death and dismemberment insurance benefits, including optional life insurance and accidental death and dismemberment benefits, provided under the Plan and described in the applicable Related Document.

2.33 Long-Term Disability Plan

Long Term Disability Plan shall mean the long-term disability benefits provided under the Plan and described in the applicable Related Document.

2.34 Medical/Prescription Drug Plan

Medical/Prescription Drug Plan shall mean the medical and prescription drug benefits, including the Chatham County employee health center, provided under the Plan and described in the applicable Related Document.

2.35 MHPAEA

MHPAEA shall mean the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

2.36 Open Enrollment Period

Open Enrollment Period shall mean the annual period designated by the Plan Administrator, during which Eligible Employees may elect to reduce their Compensation for the following Plan Year to purchase Benefits under the Plan.

2.37 Participant

Participant shall mean any Eligible Employee, Eligible Retiree or such other person as approved by the Plan Administrator, or its delegate, who is covered under the terms of this Plan; provided, however, that to the extent required under the terms of any Related Document, a person who continues to participate pursuant to such Related Document subsequent to the termination of employment with any Participating Employer shall be considered a Participant in the Plan solely with respect to such Related Document pursuant to which he or she continues to participate.

2.38 Participating Employer

Participating Employer shall mean an employer, including the County and any subsidiary, affiliate, or successor thereof, that participates in the Plan, with the prior approval of the County, as listed on Appendix A to the Plan.

2.39 Plan

Plan shall mean the Chatham County Health & Welfare Benefits Policy, as described herein and as amended from time to time.

2.40 Plan Administrator

Plan Administrator shall mean the County, or such other person or entity acting as its delegate that may be appointed by the County from time to time to administer the Plan.

2.41 Plan Year

Plan Year shall mean the twelve (12) month period beginning on January 1 and ending on December 31.

2.42 PPACA

PPACA shall mean the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010.

2.43 Pre-65 Retiree Medical/Prescription Drug Plan

Pre-65 Retiree Medical/Prescription Drug Plan shall mean the medical and prescription drug benefits, including the Chatham County employee health center, provided under the Plan to certain Eligible Retirees and dependents and described in the applicable Related Document.

2.44 Provider

Provider shall mean the applicable provider specified in Appendix B with which the Participating Employer has entered into an agreement as set forth in the applicable Related

Document to provide such Benefits under the Plan (any reference in the Plan to the “applicable Provider” shall be a reference to the Provider that has issued the applicable Related Document), or (if there is no such agreement), the County.

2.45 Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Order or QMCSO shall have the meaning as defined in Section 609 of ERISA.

2.46 Qualifying Dependent

“Qualifying Dependent,” with respect to Dependent Care Assistance Flexible Spending Account Benefits, shall mean any of the following individuals for whom the Participant is entitled to reimbursement for the expenses described in Section 6.2:

- (a) Dependent child (as defined under Code Section 152(a)(1)) of the Participant who is under the age of thirteen,
- (b) Spouse, if the Spouse is physically or mentally incapable of self-care and who lives in the same household as the Participant for more than one-half of a calendar year, or
- (c) Other dependent (as defined in Code Section 152, determined without regard to Code Sections 152(b)(1), (b)(2), and (d)(1)(B)) of the Participant who is physically or mentally incapable of self-care, and who lives in the same household as the Participant for more than one-half of a calendar year and who depends on the Participant for over one-half of his support.

With respect to paragraphs (b) and (c), these individuals must depend on the Participant for over one-half of their support; for purposes of incurring eligible dependent care assistance expenses outside the home, such individuals must also regularly spend at least eight hours each day in the Participant’s household; and the child of divorced parents shall be treated as a Qualifying Dependent of the custodial parent (as defined in Code Section 152(e)(3)(A) and applicable regulations).

An individual shall not be treated as a Qualifying Dependent if at any time during the calendar year, the relationship between the individual and the Participant is in violation of applicable local law.

2.47 Related Document

Related Document shall mean the applicable documents listed in Appendix B, which are hereby incorporated in the Plan by reference.

2.48 Retiree

Retiree shall mean a former Employee who retires from service, as set forth in the Chatham County Pension Plan, with at least ten years of credited service, making them eligible for full retirement benefits.

2.49 Five-Year Vested Retiree

Retiree shall mean a former Employee who retires from service, as set forth in the Chatham County Pension Plan with at least five years of credited service, but less than ten years of credited service, and is eligible for retiree life insurance, and no other benefits.

2.50 Deferred Vested Retiree

Retiree shall mean a former Employee who separates from service after attaining a vested status in the Chatham County Pension Plan, but has not yet attained the age or number of credited service years to retire. These participants leave Pension Plan contributions on deposit with Chatham County to receive monthly Pension Plan checks at a later date, but will not be eligible for the benefits defined in this document.

2.51 Spouse

Spouse shall mean a person who is lawfully married under any state law to the enrolling Employee, who is neither divorced nor legally separated from the enrolling Employee. Common-law spouses and domestic partners are excluded from the definition of Spouse and shall not be eligible to participate in the Plan.

2.52 Medicare Advantage Plan

Medicare Advantage Plan shall mean the medical and prescription drug benefits provided under the Plan to certain Eligible Retirees and their Spouse and described in the applicable Related Document.

2.53 USC

USC shall mean the United States Code.

2.54 USERRA

USERRA shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time. Reference to any section or subsection of USERRA includes reference to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.55 Vision Plan

Vision Plan shall mean the vision benefits provided under the Plan and described in the applicable Related Document.

2.56 Voluntary Benefits Plan

Voluntary Benefits Plan shall mean the voluntary benefits (cancer, hospital confinement, short-term disability, critical illness, whole life, universal life, and accident insurance), provided under the Plan and described in the applicable Related Documents.

2.57 Wellness Plan

Wellness Plan shall mean the wellness benefits provided under the Plan and described in the applicable Related Document.

ARTICLE III

Participation and Benefits

3.1 Eligibility and Participation

An Employee that satisfies the Plan's eligibility conditions shall become eligible to participate in all Benefit Package Options on the first day of employment (as communicated by the Plan Administrator) provided the employee enrolls and makes the required elections within the time and in the manner determined by the Plan Administrator. An Employee's participation in this Plan will begin when the reduction in his or her Compensation becomes effective. Participation in the Plan(s) shall be contingent upon receipt by the Plan Administrator of such applications, consents, proofs of birth, marriage, adoption, common ownership, elections, beneficiary designations, and other documents and information as may be prescribed by the Plan Administrator. An employee has 30 days from the date of hire to submit required documentation. Each Eligible Employee upon becoming covered by the Plan shall be deemed conclusively, for all purposes, to have assented to the terms and provisions of this Plan and shall be bound thereby.

The start date of the employee contribution and enrollment for vision, dental and health coverage will reflect their first day of employment, for all new employees.

Benefit deductions are not pro-rated. If an employee is enrolled in a benefit for one day of a payroll cycle, they will be responsible for the employee contribution associated with that pay cycle.

An Eligible Employee may also enroll his or her Spouse and/or Dependents for Benefits under the Plan to the extent specified in an applicable Related Document.

3.2 Benefits

Benefit choices under the Plan include the following elective benefits: medical benefits (including prescription drug coverage and employee health center coverage) under the Medical/Prescription Drug Plan; dental benefits under the Dental Plan; vision benefits under the Vision Plan; supplemental and dependent life/AD&D insurance under the Life Insurance Plan; critical illness, cancer, hospital confinement, short-term disability, whole life, universal life, and accident insurance under the Voluntary Benefits Plan; group legal benefits under the Group Legal Plan; Health Care Flexible Spending Account Benefits; and Dependent Care Assistance Flexible Spending Account Benefits. Benefits under the Plan also include non-elective group life/AD&D insurance under the Life/AD&D Insurance Plan, non-elective long-term disability insurance under the Long-Term Disability Insurance Plan, non-elective employee assistance benefits under the Employee Assistance Plan, and non-elective wellness benefits under the Wellness Plan. The amount, type, duration, and limitations of any Benefits are set forth in the applicable Related Documents.

3.3 Participant Elections

- (a) Participant Compensation Reduction
 - (i) During the Open Enrollment Period, each Eligible Employee may elect to reduce his or her Compensation, as applicable, to purchase coverage for the next Plan Year for Benefits offered under a Benefit Package Option. Such election shall be instituted on a pre-tax basis for the Medical/Prescription Drug Plan, the Vision Plan and the Dental Plan, as a condition for enrolling in such Benefits. Such election shall be irrevocable except as described in Section 3.3(a)(vi). Any decision regarding the modification or revocation of an election for purposes of this Section 3.3(a)(i) shall be made by the Plan Administrator on a nondiscriminatory basis and in accordance with applicable law and regulation.
 - (ii) During the Open Enrollment Period, each Eligible Employee may elect to reduce his or her Compensation by a dollar amount up to the limit set forth in the applicable Related Document for the next Plan Year for which the election is made, to be credited to his or her Health Care Flexible Spending Account to be used to pay Health Care Flexible Spending Account Benefits as provided in Article V. Such amounts shall be in addition to the Compensation reduced, if any, pursuant to Sections 3.3(a)(i) and 3.3(a)(iii). On or after January 1 of each Plan Year, an Eligible Employee who enrolls for Health Care Flexible Spending Account Benefits may not elect to change the dollar amount allocated to his or her Health Care Flexible Spending Account except as described in Section 3.3(a)(v). Any decision regarding the modification or revocation of an election for purposes of this Section 3.3(a)(ii) shall be made by the Plan Administrator on a nondiscriminatory basis and in accordance with applicable law and regulation.
 - (iii) During the Open Enrollment Period, each Eligible Employee may elect to reduce his or her Compensation by a dollar amount up to the limit set forth in the applicable Related Document for the next Plan Year for which the election is made, to be credited to his or her Dependent Care Assistance Flexible Spending Account to be used to pay Dependent Care Assistance Flexible Spending Account Benefits as provided in Article VI. Such amounts shall be in addition to the Compensation reduced, if any, pursuant to Sections 3.3(a)(i) and 3.3(a)(ii). On or after January 1 of each Plan Year, an Eligible Employee who enrolls for Dependent Care Assistance Flexible Spending Account Benefits may not elect to change the dollar amount allocated to his or her Dependent Care Assistance Flexible Spending Account except as described in Section 3.3(a)(v). Any decision regarding the modification or revocation of an election for purposes of this Section 3.3(a)(iii) shall be made by the Plan Administrator on a nondiscriminatory basis and in accordance with applicable law and regulation.

- (iv) Annual elections to reduce Compensation, as applicable, or to change existing elections shall be made during the Open Enrollment Period to be effective as of the first day of the next Plan Year. If any new benefit is added to a Benefit Package Option during a Plan Year, Eligible Employees may elect to reduce their Compensation for that benefit only during a special election period established by the Plan Administrator prior to the availability of such benefit, to the extent such a special election period is established.
 - (v) A Participant may not modify his or her Compensation reduction election at any time during the Plan Year except upon occurrence of a Change in Status (but only to the extent that the modification of the reduction election is consistent with the Change in Status within the meaning of the regulations under Code Section 125, as determined by the Plan Administrator in its sole discretion), a significant change in cost or coverage described in Section 3.11, or a special enrollment period as provided for in Code Section 9801(f).
 - (vi) Any amounts of Compensation that the Participant does not elect to be reduced shall be considered current compensation of the Participant.
- (b) A Participating Employer shall contribute to the Plan for each Coverage Period, as applicable, such amount that shall equal the total of each Participant's reduction of Compensation as elected pursuant to Section 3.3(a)(i), (ii), and (iii). The total contribution for the Coverage Period, pursuant to this Section 3.3(b), shall not exceed the amount equal to those premiums eligible to be paid, as applicable, pursuant to the Plan during the Coverage Period for which Participant elections are made plus Participant's reduction of Compensation pursuant to Sections 3.3(a)(i), 3.3(a)(ii), and 3.3(a)(iii). All contributions made by a Participating Employer shall be used for the exclusive benefit of Participants under the Plan.
- (c) The Plan Administrator may modify or terminate the elections of Key Employees, Highly Compensated Individuals and Highly Compensated Employees at such time as the applicable discrimination tests indicate that such elections must be terminated or modified in order to comply with the requirements of Code Sections 125, 129 and 105(h). Provided, however, the Plan Administrator shall not modify the elections of any individual in such a way that it will violate the requirement that unused elective contributions must be forfeited for the applicable Plan Year.
- (d) Pursuant to rules established by the Plan Administrator, Eligible Employees who are making their initial election and fail to make such election on a timely basis shall not become Participants in the Plan or be covered under any Benefit Package Option under the Plan for the remainder of the Plan Year. If an Eligible Employee (other than when making the initial election) fails to take the necessary steps to make any available election on a timely basis, unless otherwise notified by the Plan Administrator, he or she will retain his or her current elections for the following Plan Year except for the Medical/Prescription Drug, Dental, Vision, Health Care Flexible Spending Account Benefits, and/or Dependent Care Assistance Flexible

Spending Benefits, which such failure shall cause the Employee to terminate participation in the Medical/Prescription Drug, Dental, Vision, Health Care Flexible Spending Account and/or the Dependent Care Assistance Flexible Spending Account, as applicable, for the following Plan Year.

3.4 Special Rules for Retiree Benefits

An Eligible Retiree and their dependent(s) may elect to participate in either the Pre-65 Retiree Medical/Prescription Drug Plan or the Medicare Advantage Plan, the Dental Plan and the Vision Plan to the extent that the Retiree was enrolled in the comparable Benefit Package Option for active Employees on the day before retirement and provided that they enroll and make the required elections within the time and in the manner determined by the Plan Administrator in accordance with the terms set forth in the applicable Related Document. Plan and dependent elections may be changed each year during the Open Enrollment period, and are effective beginning January 1 of the following plan year. Such elections shall be instituted on an after-tax basis.

Notwithstanding the foregoing, an Eligible Retiree, or their eligible spouse aged 65 or older shall receive subsidized Medical/Prescription Drug Plan benefits only to the extent the Retiree is enrolled in the Medicare Advantage Plan. No other retiree health plan is available to Retirees aged 65 or older. If they have dependent child(ren), said child(ren) may participate in the Pre-65 Retiree Medical/Prescription Drug Plan.

Benefits for Retirees and Five-Year Vested Retirees shall also include non-elective group life insurance under the Retiree Life Insurance Plan for those Eligible Retirees who retired on or after June 1, 1999.

Employees who leave service and are defined as a Retiree in section 2.48 are eligible for vision, dental, health and life benefits. Employees who leave service and are defined as Five-Year Vested Retirees in Section 2.49 are eligible for retiree life only. Employees who leave service and are defined as a Deferred Vested Retiree in section 2.50 are not eligible for any retiree benefit programs.

Eligible Retirees and their spouses who are under age 65, as well as their dependent child(ren) may participate in the Pre-65 Retiree Medical/Prescription Drug Plan. Eligible Retirees and/or their spouses who are age 65 or greater shall only have the option of the Medicare Advantage Plan for health coverage. If the spouse of a Retiree turns 65 prior to the Retiree, their only option for medical coverage will be the Medicare Advantage Plan.

If an Eligible Retiree, or their spouse qualifies for Medicare through a disability, prior to age 65, they may contact the Human Resources Department and request enrollment in the Medicare Advantage Plan.

Benefits under Chatham County Retiree Plans are only available for the Spouse beneficiary of a Retiree, and are not available for any other type of beneficiary.

After the death of the Retiree, the spouse may remain on benefits only as long as pension payments continue to be made to them as the designated beneficiary, in accordance with the Chatham County Pension Plan, Article VII. If the pension payment made to the designated beneficiary is not sufficient to cover the cost of benefits, the cost will be billed directly to them. Failure to pay for benefits in a timely manner will result in termination of benefits.

An individual employed by Chatham County Government, who serves in the position of Chaplain for a minimum of 10 years will be entitled to retiree vision, dental, health and life coverage upon retirement.

3.5 COBRA

COBRA requires that qualified beneficiaries who would lose their group health plan coverage under the Plan due to a qualifying event be offered the opportunity for a temporary extension of coverage at group rates plus an administration fee. If a Participant or his or her Dependent might otherwise lose group health plan coverage as the result of a qualifying event as described in the applicable Related Document, the Participant or their Dependent who is a COBRA qualified beneficiary may be eligible to elect and pay for continued group health plan coverage as required under COBRA. If a qualified beneficiary loses group health plan coverage as a result of a qualifying event, the qualified beneficiary may continue participation in the group health plan for the remainder of the Plan Year in which the qualifying event occurs by completing and returning a COBRA election form to the designated COBRA administrator and then making premium payment contributions on an after-tax basis.

The applicable premium for continuation coverage may be up to 102 percent of the total cost of the coverage elected. The qualified beneficiary will have 45 days from the date continuation coverage is elected to pay the initial premium payment for continuation coverage (which shall include all monthly payments due beginning with the month coverage was lost and ending with the month in which the 45 days expires). Subsequent premium payments must be received by the COBRA administrator by the first day of the month. If subsequent premium payments are not received within 30 days of the first day of the month, the continuation coverage elected will be terminated and the qualified beneficiary will have no further rights to elect continuation coverage under the group health plan. Even if continuation coverage is elected, benefits will not be paid until all the premiums which are due have been paid without regard to any grace period.

3.6 FMLA Leave

Notwithstanding any Plan provision to the contrary, if a Participant undertakes a qualifying leave under the FMLA, to the extent required by the FMLA, a Participating Employer will continue to maintain a Participant's benefits with respect to any group health plan Benefit on (except as noted below) the same terms and conditions as if the Participant were still an active Employee, including the payment of its share of employer contributions. A

Participant undertaking an FMLA leave of absence may also revoke an existing election, and upon return from FMLA leave may make such other election for the remaining election period as may be provided for under the FMLA.

- (a) If the Participant elects to continue existing coverage for a health care Benefit and the FMLA leave is paid, pre-tax contributions will continue to be made under the Plan as elected under Section 3.3. If the FMLA leave is unpaid, participation may continue as long as the Participant pays for his or her share of the coverage in combination of one or more of the following options:
 - (i) Pre-pay option, by having such amounts withheld from the Participant's ongoing Compensation, if any, on a pre-tax basis, including unused sick days and vacation days, or by pre-paying all or a portion of his or her share of the coverage for the expected duration of the leave on a pre-tax basis out of pre-leave Compensation. Accordingly, to pre-pay his or her share of the coverage, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available, provided that pre-tax salary dollars may not be used to fund coverage during the next Plan Year;
 - (ii) Pay-as-you-go option, in which event the Participant pays for coverage on an after-tax basis. A Participating Employer shall provide the Participant with written notice of the terms of the payment of contributions during the FMLA leave. Please see the Chatham County Policy for Continuation of Benefits on Unpaid Leave.
 - (iii) By other arrangement between the Participant and the Plan Administrator.
- (b) Chatham County does not require Participants to continue coverage of health care Benefits during an unpaid FMLA leave.
- (c) If, following a period of FMLA leave, the Participant immediately returns to work, if the Participant elected to cease participation during the leave, contributions shall resume unless the Participant modifies the election, as described in Section 3.3(a)(v).

Entitlement to non-health Benefits during FMLA leave shall be determined by a Participating Employer's policy for providing such benefits when the Participant is on non-FMLA leave or non-military leave, as discussed in Section 3.8. If Participant contributions are discontinued during the leave, the Participant will be required to repay the contributions not paid during the leave on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant, or as otherwise deemed appropriate.

3.7 Military Leave of Absence

In accordance with the Chatham County Employee Handbook, Chatham County provides eligible paid military leave to eligible employees, not to exceed thirty (30) calendar days in a federal fiscal year. After an employee has exhausted paid military leave, the employee

may use accumulated annual leave or be placed on military leave without pay. If a Participant takes a military leave of absence without pay with Chatham County by reason of “service in the uniformed services” as defined in Section 4303(b)(13) of the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”), he or she may elect to continue to participate in the Plan to the extent required by USERRA with respect to the Participant and his or her Dependents, if any. Such a Participant shall be required to pay for such coverage in an amount as determined under USERRA Section 4317(a)(1)(B). The coverage for such a Participant and his or her Dependents, shall end upon the earlier of: (1) the last day of the twenty-four (24) month period beginning on the date on which the Participant’s absence begins; or (2) the day after the date on which the Participant fails to apply for or return to a position of employment with the Employer as determined under USERRA Section 4312(e).

3.8 Other Leaves of Absence

If Plan eligibility is not affected, a Participant on a non-FMLA or non-military leave of absence may continue to participate in the Plan and contributions for the Participant’s share of the cost of coverage shall be paid in accordance with the options available under Section 3.6(a), as determined by the Plan Administrator.

3.9 Reinstatement

Upon returning from FMLA or military leave, at the Participant’s election, he or she must be reinstated to the health care Benefits under which he or she was covered before commencing FMLA or military leave on the same terms as a Participant who has not taken FMLA or military leave. Upon reinstatement, such Participant shall not be charged with a break in coverage due to any period during FMLA or military leave in which health care Benefits ceased to be provided. Notwithstanding the foregoing, if required by a Participating Employer with respect to any other unpaid leave, a Participant returning from FMLA or military leave shall automatically be reinstated in the health care Benefits in which the Participant was enrolled prior to his or her FMLA or military leave. Non-health care Benefits shall be reinstated in the manner provided under the Employer’s personnel policies.

3.10 Termination of Participation

Termination of Coverage for Participants. Benefits discussed in Section 3.2 will terminate as of the date specified in the applicable Related Document. If no date is specified, or if the date is to be established by the employer, benefits will terminate at midnight on the date of termination.

- (a) Except as otherwise provided under Section 398(c), a Participant’s participation in the Plan terminates when any one of the following events occurs:
 - (i) The Participant terminates employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans,

programs, insurance contracts, and benefit components listed in Appendix B).

- (ii) The Participant ceases to qualify as an Employee or a Participant.
 - (iii) For any coverage requiring Participant contributions, contributions by the Participant are discontinued.
 - (v) All benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.
- (b) *Termination of Coverage for Dependents.* Except as otherwise provided under Section 3.9(c), a Dependent's participation in the Plan terminates when any one of the following events occurs:
- (i) The Participant terminates employment (in which case participation shall cease in accordance with the terms of Related Documents, individual plans, programs, insurance contracts, and benefit components listed in Appendix B).
 - (ii) The Participant ceases to qualify as an Employee or a Participant.
 - (iii) For any coverage requiring Participant contributions, contributions by the Participant are discontinued.
 - (iv) All benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan, by exclusion of the applicable benefit(s), or all benefits, as to Dependents, or by discontinuation of contributions by the Employer.
 - (v) The Dependent ceases to be a Dependent.
- (c) *Exceptions.* If a Participant or a Dependent is eligible for and elects continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or any similar State law, he or she will remain a participant for purposes of any Component Plan under which continuation coverage is elected while that continuation coverage remains in effect, as determined by the Administrator pursuant to applicable law.

If a Participant is offered a severance benefit upon termination of employment which includes an offer of one or more continued Benefits, then Benefits will be made available in accordance with the terms of the severance benefit.

Notwithstanding any provision of the Plan to the contrary, existing Pre-65 Retiree Health/Prescription Drug, Medicare Advantage, Dental Plan and Vision Plan benefits may continue to be offered to a surviving Spouse or surviving Dependent

of a deceased Eligible Retiree if such individual is a surviving annuitant under the terms of the Chatham County Pension Plan.

Notwithstanding any provision of the Plan to the contrary, benefits will be made available during certain periods of leave in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 and any similar applicable state law.

Termination of participation in the Plan shall automatically revoke a Participant's elections. Benefits will terminate as of the date specified in the applicable Related Document.

3.11 Special Enrollment Rights

This Section 3.10 applies notwithstanding any other provision of this Plan to the contrary. For purposes of the remainder of this Section 3.10 only, "Plan" refers only to coverage under the Benefit Package Option(s) that offer medical benefits and that are subject to Code Section 9801 (as determined by the Plan Administrator). This Section 3.10 is included in the Plan to comply with the requirements of Code Section 9801 and ERISA Section 701 and any regulations or other authoritative guidance issued pursuant to those provisions and will be construed to provide only those enrollment rights that are required by those provisions, regulations, or other authoritative guidance.

Notwithstanding any provision of this Plan to the contrary, for purposes of this Section 3.10, "Employee" is defined as described in Section 2.19, except that "Employee" does not include any person who is not, at the applicable time, a current employee of the Participating Employer (as determined by the Participating Employer).

- (a) *Special Enrollment Rights Because of Loss of Alternative Coverage.* An Employee or a Dependent who is otherwise eligible for coverage under the Plan (including, for an Employee's Dependent, any requirement that the Employee also be enrolled in the Plan) is eligible to enroll in the Plan during a Special Enrollment Period, as described in this Section 3.10(a), if,
 - (i) when coverage under the Plan was previously offered (e.g., during an initial enrollment period, a Special Enrollment Period or, if applicable, an open enrollment period), the Employee or Dependent had coverage under another group health plan or health insurance coverage ("Alternative Coverage"), and
 - (ii) the Employee or the Dependent satisfies one of the following conditions:
 - (1) the Alternative Coverage is not COBRA continuation coverage and the Alternative Coverage terminates because of a "Loss of Eligibility" (as described later in this Section 3.10(a));

- (2) the Alternative Coverage is not COBRA continuation coverage and employer contributions (including contributions by any current or former employer of the Employee or Dependent) toward the Employee's or Dependent's Alternative Coverage terminate; or
- (3) the Alternative Coverage is COBRA continuation coverage and the Alternative Coverage terminates because the COBRA continuation coverage is exhausted (as described later in this Section 3.10(a)).

"Loss of Eligibility" includes, but is not limited to, a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. For Alternative Coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "Loss of Eligibility" also includes a loss that occurs because the Employee or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another Benefit Package Option available to the affected Employee or Dependent). In addition, a "Loss of Eligibility" occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the Alternative Coverage or if the Alternative Coverage no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent.

"Loss of Eligibility" for purposes of this Section 3.10(a) does not include a loss of coverage because of a failure of the Employee or Dependent to pay for coverage on a timely basis or a loss of coverage for cause (such as for making a fraudulent claim or a misrepresentation of a material fact in connection with the Alternative Coverage).

For purposes of this Section 3.10(a), exhaustion of COBRA coverage occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a

claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

If an Employee loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), the Employee (and each otherwise eligible Dependent) is eligible for special enrollment during the Special Enrollment Period. If a Dependent loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), only the Employee and any Dependent who loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage) is eligible for special enrollment. In any case, special enrollment rights are subject to any Plan eligibility rules that condition Dependent eligibility on enrollment of the Employee.

An Employee or a Dependent who is eligible for a special enrollment under this Section 3.10(a) may be enrolled in the Plan, and the Employee may make a corresponding change in a Compensation reduction agreement under Section 3.3(a), if any, during the Employee's or Dependent's Special Enrollment Period. The Special Enrollment Period under this Section 3.10(a) ends thirty (30) days after the termination of the Alternative Coverage.

Following an election by an Employee under this Section 3.10(a), the Employee's or Dependent's coverage will become effective immediately after the Plan Administrator receives an Election Form submitted during the Special Enrollment Period electing coverage for the Employee or Dependent under the Plan. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3(a) and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

If an Employee declines coverage for the Employee or for any Dependent because the Employee or the Dependent is covered under Alternative Coverage, the Participating Employer may require that the Employee provide a written statement at the time that coverage is declined stating that the Employee is declining coverage under the Plan for the Employee or for a Dependent because the Employee or the Dependent has Alternative Coverage. Notwithstanding any other provision of this Section 3.10(a)(ii), if the Participating Employer requires such a written statement and informs the Employee of the requirement (and of the consequences of failing to provide the statement), an Employee who fails to provide such a statement will not be treated as being entitled to a special enrollment right for the Employee or the Dependent under this Section 3.10(a).

- (b) *Special Enrollment Rights Following Marriage, Birth, award of Legal Guardianship/Custody, or Adoption.* Following the marriage of an Employee or a Participant, the birth of a child, or the adoption or placement for adoption of a child, the Employee, the Employee's Dependent or the Participant's Dependent, as applicable, may enroll in the Plan during a Special Enrollment Period, as follows:
- (i) An otherwise eligible Employee may enroll himself or herself in the Plan, and make a corresponding change to a Compensation reduction agreement under Section 3.3(a), if any, during the Special Enrollment Period described in this Section 3.10(b) if an individual becomes a Dependent of the Employee through marriage, award of Legal Guardianship/Custody, birth, adoption or placement for adoption.
 - (ii) An active Participant may enroll an individual who becomes or is his or her Spouse and make a corresponding change to a Compensation reduction agreement under Section 3.3(a), if any, during the Special Enrollment Period described in this Section 3.10(b) if either (I) the individual becomes the Participant's Spouse or (II) the individual is the Participant's Spouse and a child becomes a Dependent of the Participant through award of Legal Guardianship/Custody, birth, adoption or placement for adoption.
 - (iv) An otherwise eligible Employee may elect to enroll in the Plan the Employee and an individual who becomes or is his or her Spouse and make a corresponding change to a Compensation reduction agreement under Section 3.3(a), if any, during the Special Enrollment Period described in this Section 3.10(b) if (I) the Employee and the individual become married or (II) the Employee and the individual already are married and a child becomes a Dependent of the Employee through award of Legal Guardianship/Custody, birth, adoption or placement for adoption.
 - (iv) An active Participant may enroll an individual in the Plan and make a corresponding change to a Compensation reduction agreement under Section 3.3(a), if any, during the Special Enrollment Period described in this Section 3.10(b) if the individual becomes a Dependent of the Participant through marriage, award of Legal Guardianship/Custody, birth, adoption, or placement for adoption.
 - (v) An otherwise eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee (including the Employee's Spouse, as defined in Section 2.48) in the Plan, and make a corresponding change to a Compensation reduction agreement under Section 3.3(a), if any, during the Special Enrollment Period described in this Section 3.10(b) if the individual becomes a Dependent of the Employee through marriage, award of Legal Guardianship/Custody, birth, adoption or placement for adoption.

The Special Enrollment Period under this Section 3.10(b) begins on the date of the marriage, award of Legal Guardianship/Custody, birth, adoption, or placement for adoption that gives rise to the Special Enrollment Period (or, if later, on the Participant's Participation Date) and ends thirty (30) days after that date. Following an election during a Special Enrollment Period for coverage under the Plan, the coverage will be effective, (A) for a marriage, on the date of the marriage, (B) for a Dependent's birth, on the date of birth, and (C) for a Dependent's award of Legal Guardianship/Custody, adoption or placement for adoption, on the date of the award, adoption or placement for adoption. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3(a) and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

For purposes of this Section 3.10(b), "marriage" is limited to a marriage that is recognized as a marriage for purposes of federal law.

(c) *Special Enrollment Rights Relating to Medicaid or CHIP Coverage.* To the extent required by Code Section 9801(f)(3), an Employee or a Dependent who is eligible but not enrolled may enroll in the Plan by requesting enrollment during a Special Enrollment Period described in this Section 3.10(c) in either of the following situations:

- (i) *Termination of Medicaid or CHIP Coverage.* The Employee or Dependent was covered under a Medicaid plan under Title XIX of the Social Security Act or under a State child health plan ("CHIP") under Title XXI of the Social Security Act and coverage of the Employee or Dependent under that Medicaid or CHIP plan is terminated as a result of loss of eligibility for that coverage.
- (ii) *Eligibility for Financial Assistance under Medicaid or CHIP.* The employee or dependent becomes eligible for financial assistance for coverage under the Plan, through a Medicaid plan or a State CHIP plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period described in this Section 3.10(c) is the sixty (60) day period that begins on the date of the termination of coverage described in (i) above or the date the Employee or Dependent is determined by the appropriate government agency to be eligible for the financial assistance described in (ii) above. Enrollment that is properly requested during that Special Enrollment Period will become effective immediately, after the Employee submits to the Plan Administrator an Election Form electing coverage for the Employee or Dependent under the Plan or, if applicable, on an earlier date by which coverage the Participating Employer determines coverage must be made effective to comply with Code Section 9801(f)(3). Enrollment under this Section 3.10(c) is permitted for each Employee or Dependent who experiences an event described in (i) or (ii)

above and, if the Employee must be enrolled so such a Dependent may be enrolled, for the Employee as well. Enrollment for any person, other than the Employee, who has not experienced such an event, will be permitted under this Section 3.10(c) only to the extent required by applicable law, as determined by the Participating Employer.

3.12 Significant Changes in Cost or Coverage.

Any election change permitted under this Section 3.11 must be requested, pursuant to procedures established by the Plan Administrator, within a reasonable time after the date of the event giving rise to the right to make the election change (as determined by the Plan Administrator).

- (a) *Significant Cost Changes.* If the cost payable by an Employee for coverage offered under a Benefit Package Option significantly changes during a Plan Year, as determined by the Participating Employer, the Employee may make corresponding changes to his or her election of Benefits and to a Compensation reduction agreement under Section 3.3(a). If the change is an increase in the Employee's cost of that coverage, an Employee who is a Participant may elect to replace his or her coverage with coverage available under another Benefit Package Option, if any, that offers similar coverage, as determined by the Participating Employer, or, if no other similar Benefit Package Option is available, a Participant may drop the coverage. If the change is a decrease in the Employee's cost of coverage under a Benefit Package Option, a Participant or an Employee who is eligible to become a Participant may elect that coverage.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Employee's cost for a Benefit Package Option regardless of whether the increase or decrease results from an action taken by the Employee or from an action taken by the Participating Employer.

(i) Coverage Changes.

- (1) *Curtailment Without Loss of Coverage.* If a Participant or a Participant's Dependent experiences a significant curtailment of coverage under a Benefit Package Option that is not a loss of coverage (under applicable law), as determined by the Participating Employer, the Participant may elect to revoke his or her election of that Benefit Package Option and, in lieu of that coverage, elect to receive coverage under another Benefit Package Option, if any, that offers similar coverage, as determined by the Participating Employer, and may make corresponding changes to a Compensation reduction agreement under Section 3.3(a). Coverage under a Benefit Package Option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by the Participating Employer.

- (2) *Loss of Coverage.* If a Participant or a Participant's Dependent experiences a significant curtailment of coverage under a Benefit Package Option that is a loss of coverage (under applicable law, as determined by the Participating Employer), the Participant may elect to revoke his or her election of that Benefit Package Option and, in lieu of that coverage, elect to receive coverage under another Benefit Package Option, if any, that offers similar coverage, as determined by the Participating Employer, and may make corresponding changes to a Compensation reduction agreement under Section 3.3(a). If no similar coverage is available to replace the Benefit Package Option for which a loss of coverage occurred, a Participant may elect to drop the coverage.

For purposes of this Section 3.11, "loss of coverage" means a complete loss of coverage under a Benefit Package Option and includes, for example, the elimination of a Benefit Package Option, the loss of availability of an HMO option in the area where the Participant or Dependent resides, and other similar events, as determined by the Employer. In addition, the Participating Employer, in its discretion, may elect to treat as a loss of coverage any of the following: (1) a substantial decrease in the medical care providers available under the Benefit Package Option; (2) with regard to a specific Participant or Dependent, a reduction in benefits provided under a health plan for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or (3) any similar fundamental loss of coverage.

- (b) *Addition of Option.* If the Participating Employer adds a new Benefit Package Option or if coverage under an existing Benefit Package Option is significantly improved during a Plan Year, as determined by the Participating Employer, a Participant who elected a Benefit Package Option for the Plan Year that provides similar coverage, as determined by the Participating Employer, may change his or her election of Benefits to replace that Benefit Package Option with the new or improved Benefit Package Option and may make corresponding changes to a Compensation reduction agreement under Section 3.3(a), if applicable. Any Participant, or any Employee who is eligible to become a Participant, who did not elect any Benefit Package Option for the Plan Year that provides coverage similar to that offered under a new or improved Benefit Package Option, as determined by the Participating Employer, may change his or her election of Benefits to elect the new or improved Benefit Package Option and may make corresponding changes to a Compensation reduction agreement under Section 3.3(a), if applicable.
- (c) *Changes Under Another Employer's Plan.* A Participant, or an Employee who is eligible to become a Participant, may change his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) on account of and corresponding to (A) an election change made during a period of coverage by a

Dependent or a Spouse under a plan sponsored by that person's employer, if the change is one that is permitted under that employer's plan under provisions similar to the provisions in this Section 3.11, or (B) an election change made by a Dependent or a Spouse under a plan sponsored by that person's employer that corresponds to a period of coverage that is different from the Plan Year.

- (d) *Loss of Other Group Health Coverage.* If a Participant, or an Employee who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Employee may change his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) to elect coverage for the affected individual.
- (e) *Reduction in Work Hours.* If there is a change in a Participant's employment status such that the hours of service for which the Participant is scheduled to work for a Participating Employer are reduced to average less than thirty (30) hours per week, and the Participant and his or her covered Dependents remain eligible for health coverage under the plan of the Participating Employer, the Participant may make corresponding changes to his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) to revoke an election of health coverage for the Employee and his or her covered Dependents, and elect coverage under another health plan that provides “minimum essential coverage” as defined under the PPACA. The new election of coverage must take effect no later than the first day of the second month following the month that includes the date the Participant revokes his election of coverage. The Plan may rely on the Participant's representations that he or she and any covered Dependents have enrolled in or intend to enroll in another health plan that provides minimum essential coverage within the foregoing time period.
- (f) *Enrollment in a Health Insurance Marketplace.* If a Participant (A) is eligible to change his or her Benefit Package Options during a Special Enrollment Period as determined under Section 9801 of the Code, (B) is eligible for special enrollment rights with respect to a health insurance marketplace established under the PPACA, as defined in 45 CFR Section 155.420(d), or (C) desires to enroll in a plan under a health insurance marketplace during the marketplace's annual open enrollment period, then the Participant may make corresponding changes to his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) by revoking an election of health coverage for the Employee and his or her Dependents, and electing coverage in a plan under the health insurance marketplace. Notwithstanding the foregoing, a Participant may, under the circumstances outlined under (B) or (C) in this subsection, change his or her election of Benefits and Compensation reduction agreement under Section 3.3(a) solely with respect to his or her Dependents so that one or more of his or her Dependents can elect coverage in a plan under the health insurance marketplace. The new election of coverage through the health insurance marketplace must be effective beginning no later than the day immediately following the last day of the health coverage under the Plan that is being revoked. The Plan may rely on

the Participant's representation that he or she or any covered Dependents have enrolled in or intend to enroll in a plan under the health insurance marketplace.

Nothing in this Section 3.11 shall be construed to permit a change of election with respect to any Benefit Package Option because of cost or coverage changes associated with a health care flexible spending account sponsored by any employer of an Employee or a Dependent.

ARTICLE IV

Funding and Expenses

4.1 Participating Employer Contributions

A Participating Employer shall pay from its respective general assets the cost of providing Benefits, as described in the applicable Related Document at the time and in the manner required by applicable law or by such Related Document, or at such other time(s) as the County shall deem appropriate. Notwithstanding the foregoing, to the extent that any Benefit is insured and administered by a Provider, a Participating Employer shall only be responsible for payment of premiums to the applicable Provider that has the responsibility for providing such Benefit under the Plan.

4.2 Participant Contributions

In accordance with Section 3.3, each Participant may be required to pay all or part of the cost of his or her Benefits under the Plan. Participant contributions for coverage offered under the Benefit Package Options shall be made on a pre-tax basis or after-tax basis, as applicable, pursuant to Section 3.3(a)(i). The amount of contributions required from Participants shall be determined by the Participating Employer in its sole discretion and may be increased or decreased from time to time. Participants who are expatriates will be informed by the Plan Administrator of the amount of contributions, if any, that will be required with respect to those Benefits that are offered to expatriates.

4.3 Expenses

All expenses of the Plan shall be paid by the Plan to the extent they are not paid for by a Participating Employer. A Participating Employer may be reimbursed by the Plan for any expenses it may pay for on behalf of the Plan, to the maximum extent permitted by law and the Plan.

ARTICLE V

Health Care Flexible Spending Accounts

5.1 Separate Accounts

The Plan Administrator shall maintain for each Eligible Employee who enrolls for Health Care Flexible Spending Account Benefits, a separate Health Care Flexible Spending Account to record the amount attributable to reductions of Compensation pursuant to Section 3.3(a)(ii). The Plan Administrator shall determine the Participants, Former Participants, and beneficiaries who are entitled to one or more of the allocations hereinafter described. Each such account shall consist of a record of the contributions and adjustments and be available for the payment of Health Care Flexible Spending Account Benefits as defined in Section 2.26 and described in Section 5.2. The Health Care Flexible Spending Account shall be administered in accordance with the requirements of Code Section 105(h) and Code Section 125.

5.2 Allowable Medical Expenses

A Participant who incurs eligible medical expenses within the meaning of Code Section 213(d), as further described in the applicable Related Document, for himself or herself or his or her Dependents during a Plan Year, which are not reimbursed by other means, such as insurance or another Code Section 125 arrangement, shall be eligible for Health Care Flexible Spending Account Benefits. An eligible medical expense for “medicine and drugs” within the meaning of Treasury Regulations Section 1.213-1(e)(2) shall include expenses for medicine or drugs prescribed by a qualified provider (regardless of whether the medicine or drug is available without a prescription), over-the-counter (OTC) drugs without a prescription, and menstrual products, as defined by the IRS.

5.3 Documentation of Medical Expenses

A Participant shall file a claim for Health Care Flexible Spending Account Benefits with the Claims Administrator in accordance with the requirements specified in the applicable Related Document.

5.4 Allocations to Accounts

As of each Adjustment Date, the Health Care Flexible Spending Account of each Participant, Former Participant, and beneficiary shall be adjusted by the following additions and subtractions:

- (a) There shall be added to the Health Care Flexible Spending Account of each Participant those amounts of Compensation reduced pursuant to Section 3.3(a)(ii).

- (b) There shall be subtracted the total amount of any payments made from the Health Care Flexible Spending Account to the Participant or for his or her benefit. Provided however, the total amount that is to be contributed to the Health Care Flexible Spending Account during the Plan Year will be available for reimbursement to the Participant at all times during the Plan Year, reduced as of any particular time for prior reimbursements for the same Plan Year. Provided further that if a Participant, due to termination of employment or reduction in hours, ceases to make contributions to the Health Care Flexible Spending Account during a Plan Year, the amount available for reimbursement of claims incurred prior to the date of such event shall be the Participant's annual election reduced by prior reimbursements for the same Plan Year.
- (c) If as of the end of a Plan Year the Participant has a balance in his/her Health Care Flexible Spending Account (net of claims incurred but not reimbursed), such remaining balance in excess of five hundred fifty dollars (\$550) (as may be adjusted in accordance with Notice 2020-33, beginning January 1, 2023) shall be forfeited to the extent not paid to the Participant pursuant to a claim properly submitted by the applicable claim submission deadline. All claims must be submitted on or before March 31 (or such other date as determined by the Plan Administrator) following the end of the Plan Year with the exception of those Participants whose employment has terminated during the Plan Year in which case all claims must be submitted on or before 90 days following termination of employment.

5.5 Maximum and Minimum Dollar Limitations

The maximum dollar amount available to each Participant for reimbursement pursuant to this Article V is two thousand seven hundred and fifty dollars (\$2,750) (as may be adjusted for cost-of-living increases, beginning January 1, 202), plus any amount between twenty five dollars (\$25) and five hundred fifty dollars (\$550) (as may be adjusted in accordance with Notice 2020-33, beginning January 1, 2022) that has been carried over from a prior Plan Year, pursuant to Section 5.4(c). A balance of less than twenty-five dollars (\$25) will be forfeited if no plan election is made for the coming year.

5.6 Assignability

Unless specifically provided for in the applicable Related Document, amounts payable for Health Care Flexible Spending Account Benefits may not be assigned to physicians, hospitals or other providers of services covered by the Plan.

5.7 Separate Written Plan

For purposes of Code Sections 105(b) and 106, this Article V shall constitute a separate medical reimbursement plan. To the extent necessary, other provisions of the Plan shall be incorporated by reference in this Article V.

ARTICLE VI

Dependent Care Assistance Flexible Spending Account

6.1 Separate Accounts

The Plan Administrator shall maintain for each Eligible Employee who enrolls for Dependent Care Assistance Flexible Spending Account Benefits, a separate Dependent Care Assistance Flexible Spending Account to record the amount attributable to reductions of Compensation pursuant to Section 3.3(a)(iii). The Plan Administrator shall determine the Participants, Former Participants, and beneficiaries who are entitled to one or more of the allocations hereinafter described. Each such account shall consist of a record of the contributions and adjustments and be available for the payment of Dependent Care Assistance Flexible Spending Account Benefits as defined in Section 2.17 and described in Section 6.2. It is intended that the provisions of this Article VI constitute a dependent care assistance program in accordance with Code Section 129.

6.2 Allowable Dependent Care Expenses

A Participant or Former Participant who incurs eligible household and dependent care services, as described in the applicable Related Document, during a Plan Year, for the purpose of enabling the Participant or Former Participant (or if married, the Participant or Former Participant and his or her Spouse) to be employed for any period for which there are one or more Qualifying Dependents, shall be eligible for Dependent Care Assistance Flexible Spending Account Benefits.

6.3 Documentation of Dependent Care Assistance Flexible Spending Expenses

A Participant shall file a claim for Dependent Care Assistance Flexible Spending Account Benefits with the Claims Administrator in accordance with the requirements specified in the applicable Related Document.

6.4 Allocation to Accounts

As of each Adjustment Date, the Dependent Care Assistance Flexible Spending Account of each Participant, Former Participant, and beneficiary shall be adjusted by the following additions and subtractions:

- (a) There shall be added to the Dependent Care Assistance Flexible Spending Account of each Participant those amounts of Compensation reduced pursuant to Section 3.3(a)(iii).

- (b) There shall be subtracted the total amount of any payments up to the account balance made from the Dependent Care Assistance Flexible Spending Account Benefits to the Participant or for his or her benefit.
- (c) If, as of the end of the Plan Year, the Participant has a balance in his/her Dependent Care Assistance Flexible Spending Account (net of claims incurred but not reimbursed), such remaining balance shall be forfeited to the extent not paid to the Participant pursuant to a claim properly submitted by the applicable claim submission deadline. All claims must be submitted on or before March 31 (or such other date as determined by the Plan Administrator) following the end of the of the Plan Year with the exception of those Participants whose employment has terminated during the Plan Year in which case all claims must be submitted on or before 90 days following termination of employment.

6.5 Maximum Dollar Limitations

The maximum dollar amount available to each Participant for reimbursement pursuant to this Article VI shall be five thousand dollars (\$5,000) if the Participant's filing status for federal income tax purposes is joint or head of household, and two thousand five hundred dollars (\$2,500) if the Participant's filing status for federal income tax purposes is married filing separate returns.

6.6 Assignability

Unless specifically provided for in the applicable Related Document, amounts payable under the Plan for Dependent Care Assistance Flexible Spending Account Benefits may not be used to make direct payments to providers of dependent care services.

6.7 Separate Written Plan

For purposes of Code Section 129, this Article VI shall constitute a separate dependent care assistance plan. To the extent necessary, other provisions of the Plan shall be incorporated by reference in this Article VI.

ARTICLE VII

Administration

7.1 Fiduciaries

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. The County is a “named fiduciary,” as that term is used in ERISA, with respect to the particular duties and responsibilities herein provided to be allocated to it.

7.2 Plan Administrator Responsibilities

- (a) Except for the functions reserved under the Plan to a Participating Employer, the administration of the Plan shall be under the supervision of the Plan Administrator.
- (b) The Plan Administrator shall have the sole and complete discretionary authority to interpret or construe ambiguous, unclear or implied terms in the Plan, make any findings of fact or law needed in the administration of the Plan, determine eligibility of Employees to participate in the Plan and to receive Benefits hereunder, and control and manage the operation and administration of the Plan, except to the extent that such matters are governed by the applicable Related Document or such authority is otherwise delegated pursuant to the Plan.
- (c) In addition to any other powers specified in the Plan and to any implied powers and duties that may be necessary to carry out the provisions of the Plan, the Plan Administrator shall have the following specific discretionary powers, duties, and authority with respect to the Plan:
 - (i) To establish the method of accounting for the Plan and to maintain any accounts under the Plan;
 - (ii) To prescribe any forms as it deems necessary or desirable for the efficient administration of the Plan;
 - (iii) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of the Plan or law;
 - (iv) To appoint individuals to assist in the administration of the Plan and any other agents as it deems advisable, including legal, administrative, accounting, and actuarial counsel or consultants;
 - (v) To furnish a Participating Employer, upon request, such reports with respect to the administration of the Plan as are reasonable and appropriate;

- (vi) To receive, review, and keep on file (as it deems convenient and proper) reports of Benefits;
- (vii) To receive from a Participating Employer and from Participants such information as it deems necessary or proper for the efficient administration of the Plan;
- (viii) To require Participants to complete and file applications for Benefits, or any other form that the Plan Administrator considers necessary or proper, and to require a Participant to furnish all pertinent information and documents, including receipts (the Plan Administrator shall be entitled to rely upon all such information which is furnished, including the Participant's current mailing address); and
- (ix) To take such actions as it considers necessary or appropriate to satisfy any nondiscrimination requirements of the Code that are applicable to the Plan.

7.3 Provider/Claims Administrator Responsibilities

- (a) Each of the Benefits under the Plan shall be administered by the applicable Provider and/or Claims Administrator in accordance with the terms and conditions of the applicable Related Document.
- (b) The applicable Provider and/or Claims Administrator shall be a "named fiduciary" for purposes of ERISA with respect to the portions of the Plan that are governed by the applicable Related Document and to the extent provided in such Related Document.

7.4 Delegation of Authority

The Plan Administrator has the discretion to delegate to any other person or persons (including, but not limited to, the applicable Provider and/or Claims Administrator) the authority to act on behalf of the Plan Administrator, including, but not limited to, the authority to make any Benefits determination, or to sign checks or other instruments incidental to the operation of the Plan, for which the Plan Administrator would otherwise be responsible.

7.5 Information Required for Plan Administration

Participants and other persons entitled to Benefits shall furnish the Plan Administrator with such evidence, data, or information as may reasonably be requested from time to time for the purpose of the Plan's administration.

7.6 Reliance

In administering the Plan, the Plan Administrator shall be entitled to rely (to the extent permitted by law) exclusively upon information, tables, valuations, certificates, and reports

furnished by or in accordance with the instructions of a Participant, Participating Employer, the legal, accounting, and actuarial counsel or consultants of such Participating Employer, and any applicable Provider and/or Claims Administrator.

7.7 Facility of Payment

When a person entitled to any Benefits under the Plan is under a legal disability or, in the opinion of the Plan Administrator, is in any way incapacitated so as to be unable to manage his or her financial affairs, the Plan Administrator may either (a) direct the payment of such Benefits to such person's legal representative, or to an immediate relative of such person for such person's benefit, or (b) direct the application of such Benefits for the benefit of such person in such manner as the Plan Administrator considers advisable. Any payment made in accordance with this Section 7.7 shall be a full and complete discharge of any liability for such payment under the Plan. Likewise, any payment that is made to an individual in error shall nonetheless be a full and complete discharge of the liability the Plan Administrator or other Payor intended to discharge unless otherwise determined by the Plan Administrator in writing.

7.8 Compensation of Plan Administrator

In the event the County is serving as the Plan Administrator, the County shall serve without compensation for services rendered in such capacity. Furthermore, any employee of any Participating Employer shall not receive any compensation with respect to services hereunder, except as and to the extent such person may be entitled to any Benefits.

7.9 Indemnification of Participating Employer by Participants

If any Participant or Dependent receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, he or she shall promptly reimburse the Plan for the amount of such payments and shall indemnify and reimburse a Participating Employer for any liability it may incur for failure to withhold federal, state, or local income tax or Social Security tax from such payments or reimbursements. An alternate recipient under a QMCSO is entitled to only those Benefits from the Plan as are designated by the QMCSO and promptly shall return any payment, or portion thereof, made by mistake of fact or law. The Plan Administrator may offset the future payment of Benefits for any recipient who refuses to return an erroneous payment, in addition to pursuing any other remedies provided by law.

7.10 Payment

Unless specifically provided to the contrary under the terms of this Plan or a Related Document, payment of any claim for Benefits will be made to the Participant unless he or she has previously authorized, in accordance with applicable Plan terms, the payment to a person rendering services, treatment or supplies. If the Participant dies before all Benefits have been paid to the Participant, the remaining Benefits, if any, will be paid to the Participant's estate or to any person or corporation that has been approved by the Plan Administrator to be entitled to payment. Such payment will fully discharge the Plan's

obligations with respect to that claim for Benefits. If a Participant is a minor, or not competent to give a valid receipt for payment of any Benefit due to him or her under the Plan and if no request for payment has been received from a duly appointed guardian or other legally appointed representative of that person, payment may be made directly to the individual or institution that has assumed the custody or the principal support of that person.

7.11 Subrogation and Reimbursement

The Plan does not provide primary coverage for expenses associated with an injury, illness or condition caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). In the event that an individual receiving benefits under the Plan (“Covered Individual”) sustains an injury, illness or condition, as a result of an action of a third party, and the Plan pays for costs associated with such injury, illness or condition, the Covered Individual including a covered Employee acting as parent or guardian on behalf of his or her covered Dependent child(ren) (“Parent”), agree to the following provisions with respect to any expenses the Plan advances for which a Recovery may be available. By accepting Plan coverage, a Covered Individual and/or Parent, agree the Plan would not have covered any of those expenses, but for this agreement to reimburse the Plan in full in accordance with this Section.

(a) Definitions:

- (1) “Insurance Coverage” means any non-Plan coverage providing medical expense coverage or liability coverage, including uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any other insurance coverage.
- (2) “Responsible Party” means any party (other than the Plan) actually or potentially responsible for making any payment to a Covered Individual or Parent due to a Covered Individual’s injury, illness, or condition, including the party’s insurer.
- (3) “Recovery” means any amount a Covered Individual or Parent receives from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, including amounts designated as pain and suffering damages, non-economic damages, non-medical damages, or general damages, and even if the Responsible Person is not liable or denies liability. A Recovery includes amounts family members receive because of or related to a Covered Individual’s injury, illness, or condition.

- (b) Subrogation Rights: The Plan has the right to be subrogated to the Covered Individual's rights against any third parties which arise from such injury, illness or condition.
- (c) Reimbursement Rights: The Plan is not required by law to cover health expenses that a Covered Individual may be able to recover from a third party, however, if the Plan advances those expenses (if otherwise payable under the Plan), the Plan has the right to be fully reimbursed (to the extent of benefits paid and the Covered Individual's or Parent's net Recoveries (i.e., after reduction for reasonable attorney's fees and recovery costs) by the Covered Individual or Parent if such Covered Individual obtains any financial recovery from any source, including such Covered Individual's or Parent's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by a Participating Employer, any Responsible Party or Insurance Coverage, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury, illness, or condition, before the Covered Individual, Parent or anyone else may keep any portion of the Recoveries.
- (d) By accepting benefits under the Plan in connection with such an injury, illness or condition, the Covered Individual or Parent assigns any recovery to the Plan and authorizes such Covered Individual's attorney, personal representative, Claims Administrator or Provider to reimburse the Plan. The Covered Individual and/or Parent, promise to pay the Plan the amount it is due under this section. This promise shall be an enforceable contract governed by the State of Georgia law. Each Covered Individual and/or Parent agrees to pay any amount he or she receives because of the Covered Individual's injury, illness, or condition, to the Plan to the extent necessary to fully reimburse the Plan.
- (e) The Plan is entitled to full reimbursement of the amount the Plan advanced to pay for treatment of the Covered Individual's injury, illness, or condition before the Covered Individual and/or Parent:
 - (i) is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual and/or Parent has other costs or the Covered Individual suffered other injuries not paid for or compensated by the Plan (notwithstanding any "Make Whole Doctrine");
 - (ii) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;
 - (iii) without reduction for attorneys' fees and other costs incurred by the Covered Individual and/or Parent in making a recovery without the prior express written consent of the Plan (notwithstanding any "Fund Doctrine," "Common Fund Doctrine," or "Attorneys' Fund Doctrine");
 - (iv) if the Covered Individual and/or Parent recovers less than all the damages he or she sought, the Plan's repayment rights shall not be reduced. The Covered Individual and/or Parent promise not to assert, and hereby, waive

any equitable defenses to or limitations on the Plan's right to recover the amount due under this section; and

- (v) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.
- (f) Covered Individual and/or Parent will hold Recovery in trust for the Plan: Each Covered Individual and/or Parent shall hold any Recovery in trust for the Plan's benefit to the extent of the Plan's repayment right. Each person holding any Recovery in trust for the Plan shall be a Plan fiduciary for that limited purpose, and shall be personally liable to the Plan for any loss the Plan suffers as a result of his or her fiduciary breach. However, such a person shall not have any other fiduciary powers or rights. For example, such a person will not be eligible for the indemnification or insurance protection provided to other Plan fiduciaries, notwithstanding anything else to the contrary.
- (g) If the Plan incurs costs, such as attorney's fees, to recover amounts it is due under this section, those costs shall be added to the amount the Plan is entitled to recover under this section.
- (h) The Plan will automatically have a first priority lien on any Recovery to the extent of benefits advanced by the Plan for the treatment of the illness, injury, or condition to which the recovery relates. The lien shall arise on any Recovery whether by settlement, judgment, insurance, net of reasonable attorney's fees and recovery costs. The lien may be enforced against any party who possesses the Recovery.
- (i) Covered Individual and/or Parent hereby assign, all rights of recovery they have against anyone due to injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan, and agree the Plan may assert this right independently of the Covered Individual. Nothing in this subsection shall preclude a Covered Individual and/or Parent from pursuing such a claim while the Plan is not independently pursuing it.
- (j) A Covered Individual's attorneys and agents shall be bound by all the provisions of this section, to the same extent as the Covered Individual. Their attorneys' and agents' violations of this section shall be treated as a violation by the Covered Individual and/or his or her Parent of their obligations.
- (k) Requirements for Covered Individuals to Receive Benefits: Notwithstanding any other provision of the Plan to the contrary, the payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual and/or Parent:
 - (1) informing the Plan Administrator of the action to be taken by the Covered Individual and/or Parent;
 - (2) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and

- subrogated to any right of recovery the Covered Individual and/or Parent has against a third party;
- (3) refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan);
 - (4) cooperating in doing what is reasonably necessary to assist the Plan in any recovery Plan's efforts to recover the amount it is due, including permitting the Plan or its agents to conduct investigations reasonably needed to enforce the Plan's rights under this section. The Covered Individual and/or Parent must notify the Plan Administrator that they are considering seeking a Recovery or similar amounts no later than 30 days after they begin considering pursuing such a claim. The Covered Individual and/or Parent shall provide all information requested by the Plan, any Claims Administrator, or their representatives including, submitting forms or statements as the Plan may reasonably request; and
 - (5) agreeing that the Plan may bring suit to recover amounts due under this section in Federal or state court in the State of Georgia or in any other court of competent jurisdiction, and agree to submit to each such jurisdiction, waiving whatever rights they might have by reason of their present or future domicile.

If a Covered Individual and/or Parent, or their attorneys or agents, fail to repay the Plan, cooperate with the Plan in its efforts to recover such amounts, or do anything to hinder or prevent such a recovery, in addition to any other remedies available to the Plan, they shall forever cease to be entitled to any further Plan benefits, except to the extent prohibited by the Affordable Care Act. In addition, the Covered Individual and/or Parent, by accepting Plan benefits, authorize the Employer and the Plan to use the self-help remedy of withholding any amounts due under this section from any other amounts they are owed by the Employer, Plan, or any other Employer-sponsored arrangement. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described in this Section in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

Notwithstanding the foregoing, the Plan reserves its right to negotiate with the parties concerned any amount of Recovery that it deems acceptable and satisfactory.

7.12 Right of Recovery of Overpayments

Whenever payment for a claim for Benefits has been made in excess of the maximum limit for that claim under the Plan, the Plan will have the right to recover such amounts to the extent of the excess from whoever received the excess payment and/or the Participant and each of them shall be obligated to pay such amount to the Plan. If Plan benefits are paid by mistake, the recipient must repay the mistaken payment to the Plan immediately. By accepting Plan coverage, a Covered Individual is deemed to agree that if he or she does not

repay the mistaken payment to the Plan promptly after it requests repayment, the Covered Individual will pay all attorneys' fees the Plan incurs in successful attempts to recover such amounts. In addition to any other recovery rights it may have, the Plan shall have the right to recoup the overpayment from any future benefits payable to the Covered Individual or his or her covered Spouse or Dependent. To enforce its repayment rights, the Employer shall have a first priority, equitable lien on all Plan benefits paid to or on behalf of the Covered Individual. The Employer's rights under this Section are in addition to any other remedies it may have in law or equity, and the Plan Administrator's enforcement of the Employer's rights under this Section shall not curtail the Employer's right to enforce any other remedies it may have.

7.13 Coordination of Benefits

If a Participant or his or her covered Spouse or other Dependent is participating in another group health plan, the payment of Benefits will be determined in accordance with the rules in effect with respect to any applicable Related Document, as stated in such Related Document or one or more written documents approved by the Plan Administrator or the Board with respect to such Related Document. Any other non-group health plan shall always be primary, except to the extent prohibited by law.

7.14 Government-Provided Benefits

The Plan does not provide Benefits in lieu of, and does not affect any requirement for coverage by, any benefits provided under any federal, state or local government including, without limitation, any workers' compensation insurance or benefit.

ARTICLE VIII

Amendment And Termination

8.1 Reservation of Right to Amend or Terminate Plan

- (a) The County intends to continue the Plan indefinitely. However, pursuant to Section 402(b)(3) of ERISA, the Board, or its authorized representative pursuant to delegated authority, may at any time and for any reason amend, modify, change, or terminate the Plan, prospectively or retroactively. Plan amendments may include, but are not limited to, elimination or reduction in the level or type of Benefits provided to any class or classes of Participants and their Dependents, and any amendment to increase or decrease Plan coverage contributions for any Participants and/or their Dependents. No amendment that affects the rights or obligations of the Plan Administrator may be made without the Plan Administrator's consent. Notwithstanding the foregoing, Appendices A and B to the Plan may be replaced by the County without the need for formal amendment to the Plan.
- (b) The County may enter into contracts with Providers and/or Claims Administrators or provide Benefits exclusively through such other funding arrangement that the County may establish for the purpose of providing Benefits under the Plan, as the County in its discretion may deem appropriate.

8.2 Preservation of Rights

The County does not guarantee the continuation of any Benefits during employment or after termination thereof, nor does it guarantee any specific level of Benefits or contributions. Benefits provided under this Plan are at the County's discretion and do not create a contract of employment.

ARTICLE IX

HIPAA Privacy and Security

The following terms and conditions shall apply with respect to any Health Care Component of the Plan from whom the Plan Sponsor receives Protected Health Information subject to HIPAA:

9.1 Definitions

Whenever used in this Article, the following terms shall have the respective meanings set forth below.

- (a) *Affiliated Covered Entities* – means legally separate Covered Entities that are all under common control or common ownership and are designated as an affiliated group of covered entities in accordance with 45 CFR Section 164.103. For purposes of this definition, “common control” exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity; and “common ownership” exists if an entity or entities possess an ownership or equity interest of five (5) percent or more of another entity.
- (b) *Covered Entity* – means (i) a Health Plan, (ii) a Health Care Clearinghouse, or (iii) a Health Care Provider who transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR Section 160.103. For purposes of this Article, a Covered Entity shall include the Health Care Components of the Plan.
- (c) *Employer* – means Chatham County Board of Commissioners and any Participating Employer. For purposes of this Article, Employer shall also mean Plan Sponsor.
- (d) *Health Care* – means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR Section 160.103. Health Care includes, but is not limited to, the following:
 - (i) Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and
 - (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.
- (e) *Health Care Clearinghouse* – has the meaning set forth in 45 CFR Section 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that performs either of the following functions:

- (i) Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
 - (ii) Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.
- (f) *Health Care Component* – means a component or combination of components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR Section 164.105(a)(2)(iii)(C) and from whom the Plan Sponsor receives protected health information subject to HIPAA.
- (g) *Health Care Operations* – has the meaning set forth in Section 10.4.
- (h) *Health Care Provider* – has the meaning set forth in 45 CFR Section 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.
- (i) *Health Care Treatment* – has the meaning set forth in Section 10.4.
- (j) *Health Information* – has the meaning set forth in 45 CFR Section 160.103 and includes information, whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and electronic data, that is created or received by a Health Care Provider, Health Plan, the Employer, life insurer, school or university, or Health Care Clearinghouse that relates to the past, present, or future physical or mental health or condition of an Individual, the provision of Health Care to an Individual, or the past, present, or future payment for the provision of Health Care to an Individual.
- (k) *Health Insurance Issuer* – has the meaning set forth in 45 CFR Section 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. Such term does not include a group health plan (within the meaning of 45 CFR Section 160.103).
- (l) *Health Plan* – means an individual or group plan that provides or pays the cost of medical care, and includes a group health plan, a Health Insurance Issuer, an HMO and such other plans or arrangements as are set forth in 45 CFR Section 160.103, including the Health Care Components of the Plan.
- (m) *Hybrid Entity* — means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components [in accordance with

45 CFR Section 164.105(a)(2)(iii)(C)] for purposes of fulfilling the hybrid entity requirements of HIPAA, as defined in 45 CFR Section 164.103. For purposes of this definition, “covered functions” means those functions of a Covered Entity, the performance of which makes the entity a Health Plan, Health Care Provider or Health Care Clearinghouse.

- (n) *Individual* – has the meaning set forth in 45 CFR Section 164.501 as the person who is the subject of Protected Health Information.
- (o) *Individually Identifiable Health Information* – has the meaning set forth in 45 CFR Section 160.103 and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, Employer, or Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.
- (p) *Organized Health Care Arrangement* – has the meaning set forth in 45 CFR Section 160.103 and includes:
 - (i) A group health plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such group health plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such group health plan;
 - (ii) A group health plan and one (1) or more other group health plans each of which are maintained by the same Plan Sponsor; or
 - (iii) The group health plans described in paragraph (ii) of this definition and Health Insurance Issuers or HMOs with respect to such group health plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such group health plans.
- (q) *Plan Administration Functions* – means administrative functions performed by the Plan Sponsor on behalf of the Plan, excluding functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.
- (r) *Plan Sponsor* – generally means the entity defined in Section 3(16) (B) of ERISA, 29 USC Section 1002(16)(B).
- (s) *Privacy Notice* – means the notice of privacy practices that sets forth the uses and disclosures of Protected Health Information that may be made by the Plan under HIPAA, as more fully described in 45 CFR Section 164.520.

- (t) *Privacy Official* – means the Individual appointed by the Employer, or its delegate, on behalf of the Plan and named in Section 9.6 hereof who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Employer’s Health Plans and Health Care Providers, in accordance with 45 CFR Section 164.530.
- (u) *Protected Health Information* – means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 USC Section 1232g), employment records held by the Covered Entity in its role as an Employer, and other records described in 20 USC Section 1232g(a)(4)(B)(iv).
- (v) *Required by Law* – means a mandate contained in law that compels an entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental or inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits, as more fully described in 45 CFR Section 164.103.
- (w) *Summary Health Information* – has the meaning set forth in 45 CFR Section 164.504 and includes information that summarizes the claims history, expenses, or types of claims by Individuals for whom the Plan Sponsor has provided benefits under the Plan, and from which the following information has been removed:
 - (i) Names;
 - (ii) Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, (if permitted under 45 CFR Section 164.514(b)(2)(i)(B));
 - (iii) All elements of dates (except year) directly relating to the Individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission or discharge date) and all ages over 89, except that ages and elements may be aggregated into a single category of age 90 or older;

- (iv) Other identifying numbers, such as Social Security, telephone, fax, account or medical record numbers, e-mail or Internet addresses, URLs or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;
- (v) Facial photographs or biometric identifiers (e.g., finger prints);
- (vi) Any other unique identifying number, characteristic, or code; and
- (vii) Any information of which the Employer has knowledge that could be used alone or in combination with other information to identify an Individual.

9.2 Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer and its Affiliates if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan, including analyzing Plan costs and the effectiveness of the Plan's administration or for such other purposes as may be permitted under 45 CFR Section 164.504(f)(1)(ii) and the provisions of this Article.

9.3 Disclosure of Protected Health Information to Employer

The Plan will disclose Protected Health Information to the Employer or its Affiliates only in accordance with 45 CFR Section 164.504(f) and the provisions of this Article.

9.4 Use and Disclosure of Protected Health Information

Protected Health Information disclosed by the Plan to the Employer or its Affiliates in accordance with the provisions of this Article may only be used by the Employer or its Affiliates for the following purposes related to Health Care Treatment, payment for Health Care and Health Care Operations without the covered Individual's written authorization (that meets the requirements of 45 CFR Section 164.508) (hereinafter "permitted uses and disclosures"):

- (a) *Affiliated Companies* – means the subsidiary and affiliated companies of the Employer that are participating employers in the Plan.
- (b) *Health Care Treatment*. – means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another and such other forms of treatment as may be permitted under 45 CFR Section 164.501.
- (c) *Payment for Health Care*. – means activities undertaken by the Plan to obtain premiums or reimbursement, or to determine or fulfill its responsibility for

coverage and provision of Plan benefits that relate to an Individual to whom Health Care is provided. These activities include, but are not limited to, the following:

- (i) Determination of eligibility, coverage and cost sharing amounts, such as, cost of a benefit, Plan maximums and co-payments as determined for an Individual's claim;
 - (ii) Coordination of benefits;
 - (iii) Adjudication of health benefit claims, including appeals and other payment disputes;
 - (iv) Subrogation of health benefit claims;
 - (v) Establishing Employee contributions;
 - (vi) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
 - (vii) Billing, collection activities and related Health Care data processing;
 - (viii) Claims management and related Health Care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
 - (ix) Obtaining payment under a contract for reinsurance, including stop-loss and excess of loss insurance;
 - (x) Medical necessity reviews or reviews of appropriateness of care or justification of charges;
 - (xi) Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
 - (xii) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following Protected Health Information may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number, name and address of the Health Care Provider and/or health plan);
 - (xiii) Reimbursement to the Plan; and
 - (xiv) Such other payment activities as may be permitted under 45 CFR Section 164.501.
- (d) *Health Care Operations.* – means the activities of a Covered Entity under 45 CFR Section 164.501 including, but not limited to:

- (i) Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;
- (ii) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care providers and patients with information about treatment alternatives and related functions that do not include treatment;
- (iii) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner performance, rating Health Care provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- (iv) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;
- (v) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- (vi) Business planning and development, such as conducting cost-management and planning related analysis associated with managing and operating the plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- (vii) Business management and general administrative activities of the Plan, including, but not limited to:
 - (1) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (2) Customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
- (viii) Resolution of internal grievances;
- (ix) The sale, transfer, merger or consolidation of all or part of the Covered Entity with another Covered Entity (within the meaning of 45 CFR Section 160.103), or an entity that following such activity will become a Covered Entity (within the meaning of 45 CFR Section 160.103), and due diligence related to such activity;

- (x) Consistent with the applicable requirements of 45 CFR Section 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Covered Entity; and
- (xi) Such other Health Care Operations as may be permitted under 45 CFR Section 164.501.
- (e) *Organized Health Care Arrangement.* On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of an Organized Health Care Arrangement. If the Plan participates in an Organized Health Care Arrangement, it may disclose Protected Health Information about an Individual to another Covered Entity that participates in the Organized Health Care Arrangement for any Health Care Operation activities of the Organized Health Care Arrangement.
- (f) *Pursuant to an Authorization.* The Plan may use or disclose Protected Health Information pursuant to an authorization that meets the requirements of 45 CFR Section 164.508.

9.5 Employer Certification and Responsibility

The Employer hereby certifies that this Section constitutes an amendment of the governing Plan documents that complies with the requirements of 45 CFR Section 164.504(f) and that the Employer shall comply with the conditions of disclosure set forth below.

The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose Protected Health Information to the Employer or Affiliated Companies and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR Section 164.504(f). Additionally, the Employer and Affiliated Companies agree:

- (a) To use or disclose Protected Health Information to the extent permitted in Section 9.4, to the extent provided under HIPAA, or as otherwise Required by Law;
- (b) To ensure that any and all of their agents or subcontractors to whom the Employer or Affiliated Companies provide Protected Health Information received from the Plan agree in writing, to the same restrictions and conditions as are imposed upon the Employer and Affiliated Companies;
- (c) Not to use or disclose Protected Health Information for employment-related actions or in connection with any other benefit or employee benefit plan of the Employer and Affiliated Companies;
- (d) To report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the permitted uses and disclosures in Section 9.4 of which it becomes aware;

- (e) To make Protected Health Information available to Individuals in accordance with 45 CFR Section 164.524;
- (f) To make Protected Health Information available for Individual's amendment and incorporate any amendments in accordance with 45 CFR Section 164.526;
- (g) To make the information available that will provide Individuals with an accounting of disclosures in accordance with 45 CFR Section 164.528;
- (h) To make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services upon request for purposes of determining compliance with HIPAA;
- (i) If feasible, to return or destroy all Protected Health Information received from the Plan that the Employer or Affiliated Companies maintain in any form and retain no copies of such information when such Protected Health Information is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer or Affiliated Companies, as applicable, will limit further uses and disclosures of the Protected Health Information to those purposes that make the return or destruction of the information infeasible; and
- (j) To ensure that adequate separation required by 45 CFR Section 164.504(f) and provided in Sections 9.6, 9.7 and 9.8 between the Plan, and the Employer and its Affiliates, is established and maintained.

9.6 Employees with Access to Protected Health Information

In accordance with HIPAA, the Plan shall disclose Protected Health Information only to the following Employees or classes of Employees:

- (a) The designated HIPAA Privacy Official and HIPAA Security Official,
- (b) The Director of Human Resources
- (c) The Human Resources Benefits Department, and
- (d) Any other Individual who is under the control of the Employer or Affiliated Companies and who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the Plan in the ordinary course of business (within the meaning of 45 CFR Section 164.504(f)(2)(iii)) and who has been designated, in writing, by the Privacy Official.

9.7 Limitations to Protected Health Information Access and Disclosure

Access to and use of Protected Health Information by the Individuals described in Section 9.6 above shall be restricted to those Plan Administration Functions that the Employer or Affiliated Companies perform for the Plan and/or the uses set forth in Section 9.4. Such access or use shall be permitted only to the extent necessary for these Individuals to perform their respective duties for the Plan.

9.8 Noncompliance

Instances of noncompliance with the permitted uses and disclosures of Protected Health Information set forth in Section 9.4 by Individuals described in Section 9.6 shall be addressed in the following manner:

- (a) *Potential Sanctions:* The Plan shall establish and communicate a set of sanctions that are applicable to a wide variety of breaches of covered health policies and procedures. The range of sanctions may include:
 - (i) Additional/remedial privacy training;
 - (ii) Counseling by supervisor;
 - (iii) Notation in personnel files;
 - (iv) Letter of reprimand from supervisor;
 - (v) Removal from being within the firewall;
 - (vi) Removal from current position;
 - (vii) Suspension from current position;
 - (viii) Termination of employment; and
 - (ix) Other sanctions as the Privacy Official shall deem appropriate.
- (b) *Administration of Sanctions:* The Plan, in consultation with the Privacy Official, shall develop a procedure for:
 - (i) Determining the appropriate sanction to be administered to a member of its “workforce” for a breach of a covered health policy or procedure;
 - (ii) Determining who (e.g., the Privacy Official, etc.) has responsibility for assessing the sanction against the “workforce” member; and
 - (iii) Determining a process for administering any sanctions.

For purposes of this subparagraph, “workforce” shall mean an Employee, volunteer, trainee, or other person who performs duties under the direct control of the Covered Entity, whether or not he or she is paid by the Covered Entity.

- (c) *Documentation of Sanctions:* The Privacy Official, on behalf of the Plan, shall develop and implement a system for maintaining a record of each sanction administered. The record of sanctions shall conform to the record keeping and documentation standards and implementation specifications required under HIPAA. The Plan will have the option of having this record maintained by the Privacy Official or his or her designee.

9.9 Nondisclosure of Protected Health Information by HMOs

A Health Insurance Issuer or HMO that provides services to the Plan is not permitted to disclose Protected Health Information to the Employer except as would be permitted by the Plan under this Article and only if a Privacy Notice is maintained and provided as required by 45 CFR Section 164.520(a)(2)(ii).

9.10 Notice to Employees

The Plan shall not disclose, and may not permit a Health Insurance Issuer or HMO providing services to the Plan to disclose, Protected Health Information to the Employer or Affiliated Companies unless a separate statement, as set forth in 45 CFR Section 164.520(b)(1)(iii)(C), describing the intention of the Plan to make such disclosure, is included in a Privacy Notice that is maintained and provided as required by 45 CFR Section 164.520.

9.11 Policies and Procedures

The Employer shall adopt on behalf of the Plan, policies and procedures as necessary to administer the terms and conditions of this Article and the Plan’s obligations under HIPAA. Such policies and procedures shall meet the requirements of 45 CFR Section 164.530(i).

9.12 Hybrid Entity Designation

On behalf of the Plan, the Employer has designated this Plan as a Hybrid Entity. The following rules shall therefore apply:

- (a) References to:
 - (i) The Plan or a Covered Entity in this Article shall refer to the Health Care Component of the Plan or Covered Entity;
 - (ii) Health Plan, Health Care Provider or Health Care Clearinghouse in this Article shall refer to the Health Care Component of the Covered Entity if such Health Care Component performs the functions of a Health Plan, Health Care Provider or Health Care Clearinghouse, as applicable;

- (iii) Protected Health Information in this Article shall refer to Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan or Covered Entity; and
 - (iv) Electronic Protected Health Information shall refer to electronic Protected Health Information that is created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan or Covered Entity.
- (b) The Plan shall be responsible for complying with the requirements of HIPAA, as set out in this Article, and as fully set forth in 45 CFR Section 164.105(a), including, but not limited to, ensuring:
- (i) That the Health Care Component does not disclose Protected Health Information and electronic Protected Health Information to another component of the Plan under circumstances where HIPAA would prohibit such disclosure if the Health Care Component and the other component were separate and distinct legal entities;
 - (ii) That a Health Care Component whose activities would make it a business associate does not use or disclose Protected Health Information or electronic Protected Health Information that it creates or receives from or on behalf of the Health Care Component in a way prohibited by HIPAA; and
 - (iii) That if a person performs duties for both the Health Care Component in the capacity of an Employee, volunteer, trainee or other person performing duties under the direct control of such component and for another component of the entity in the same capacity with respect to that component, such Employee, volunteer, trainee or other person performing duties under the direct control of such component must not use or disclose Protected Health Information created or received in the course of or incident to the member's work for the Health Care Component in a manner prohibited by HIPAA.
- (c) The Plan shall retain documentation of the Hybrid Entity designation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR Section 164.530(j).

9.13 Affiliated Covered Entities Designation

On behalf of the Plan, the Employer may designate, with the concurrence of the Privacy Official, that the Plan, or any Health Care Component of the Plan, is part of a single Affiliated Covered Entity for purposes of complying with this Article and HIPAA. If such designation is made, the following rules shall apply:

- (a) The Affiliated Covered Entity shall ensure that Affiliated Covered Entity shall comply with the requirements of HIPAA, as set forth in this Article, and as set forth in 45 CFR Section 164.105.

- (b) If the Affiliated Covered Entity combines the functions of a Health Plan, Health Care Provider, or Health Care Clearinghouse, the Affiliated Covered Entity shall meet the requirements of 45 CFR Section 164.504(g) regarding multiple covered functions.
- (c) The Plan shall document, in writing or electronically, which Health Care Components of the Plan constitute the Affiliated Covered Entities and retain such documentation for six (6) years from the date it was created or was last in effect, whichever is later, in accordance with 45 CFR Section 164.530(j).

9.14 Electronic Data Security Standards

The Plan shall apply the following provisions (a) and (b) to enable it to disclose electronic Protected Health Information to the Employer and Affiliated Companies and acknowledges receipt of a written certification from the Employer that the Plan has been so amended to comply with the requirements of 45 CFR Section 164.314(b).

- (a) Except when electronic Protected Health Information is disclosed to the Employer or Affiliated Companies with the safeguards set forth in (i) through (iii) below, the Plan and Employer shall reasonably and appropriately safeguard electronic Protected Health Information that is created, received, maintained, or transmitted to or by the Employer or Affiliated Companies on behalf of the Plan.
 - (i) The Plan may disclose electronically Summary Health Information to the Employer or Affiliated Companies if requested by the Employer or Affiliated Companies for the purpose of obtaining premium bids from Health Plans, for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan in accordance with 45 CFR Section 164.504(f)(1)(ii).
 - (ii) The Plan, a health insurance issuer or HMO with respect to the Plan, may disclose electronically to the Employer or Affiliated Companies information on whether an Individual is participating in the Plan, or is enrolled in or has dis-enrolled from a Health Insurance Issuer or HMO offered by the Plan in accordance with 45 CFR Section 164.504(f)(1)(iii).
 - (iii) The Plan may disclose Protected Health Information to the Employer or Affiliated Companies for which it has obtained from the Individual about which the Protected Health Information concerns, a valid authorization that meets the requirements of 45 CFR Section 164.508.
- (b) Additionally, the Employer agrees on behalf of itself and its Affiliates to comply with 45 CFR Section 164.314, including the following:
 - (i) The Employer and Affiliated Companies shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected

Health Information that it creates, receives, maintains or transmit on behalf of the Plan.

- (ii) The Employer and Affiliated Companies shall ensure that the separation requirements applicable to the Plan set out in Sections 9.6, 9.7 and 9.8 of this Article and 45 CFR Section 164.504(f)(2)(iii) shall be supported by reasonable and appropriate security measures.
 - (iii) The Employer and Affiliated Companies 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 the information.
 - (iv) The Employer shall report to the Plan any security incident (within the meaning of 45 CFR Section 164.304) of which it becomes aware.
- (c) The Plan and the Employer and Affiliated Companies shall take any such further action as is required to comply with the electronic data security standards requirements of HIPAA.

9.15 Other Uses and Disclosures of Protected Health Information

The Plan may disclose Protected Health Information to such other entities and under such circumstances as permitted under HIPAA and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA.

9.16 Breach Reporting

The Employer shall promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

ARTICLE X

CLAIMS PROCEDURES

10.1 Claims Procedures in General

This Article is based on final regulations issued by the Department of Labor and published in the Federal Register on December 19, 2016, as amended on November 29, 2017, and codified at 29 C.F.R. Section 2560.503-1 and, for any claim involving coverage that is subject to PPACA and is not a Grandfathered Plan, the Interim Final Regulations issued by the Departments of the Treasury, Labor and Health and Human Services on July 23, 2010, as amended on June 24, 2011, and codified at 29 C.F.R. Section 2590.715-2719. If any provision of this Article conflicts with the requirements of those regulations, the requirements of those regulations will prevail. For any insured Benefits offered under the Plan, the claims procedures established by the Insurer for that benefit will apply instead of the procedures described in this Article except to the extent those procedures conflict with the requirements of applicable law.

Notwithstanding any provision of this Article to the contrary, for any claim for a benefit under the Plan that is not subject to ERISA, the claims procedures that apply for benefits other than health and disability benefits will apply, except that any requirement to provide notice about any right that may apply under ERISA will not apply to such a claim.

10.2 Initial Claims

If a Participant or a Participant's Spouse, Dependent or beneficiary (referred to in this Article as a "Claimant") desires any Benefit under this Plan, the Claimant may file a claim with the Plan Administrator, Claims Administrator, or Insurer, if applicable (referred to in this Article as the "Reviewer"). "Claimant" also includes any properly authorized representative (as determined by the Reviewer) of the person who is the subject of the claim. All claims must be submitted in writing, except to the extent oral notice is permitted for certain urgent care health benefit claims, as described in this Article. The Reviewer will review the claim itself or appoint an individual or an entity to review the claim.

- (a) *Non-Health and Non-Disability Benefit Claims.* For a claim for a benefit other than a health or disability benefit, the Claimant will be notified within ninety (90) days after the claim is filed whether the claim is allowed or denied, unless the Claimant receives written notice from the Reviewer before the end of the ninety (90) day period stating that special circumstances require an extension of the time for decision, such extension not to extend beyond the day which is one hundred eighty (180) days after the day the claim is filed.
- (b) *Health Benefit Claims.*

- (i) *Urgent Care Claims.* If a claim is for urgent care health benefits, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan receives the claim, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Reviewer will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notice may be oral unless written notice is requested by the Claimant. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Reviewer will notify the Claimant of the Plan's determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

If any person fails to follow the Plan's procedures for submitting an urgent care claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Plan Administrator or Reviewer will notify the potential Claimant, as soon as reasonably possible but no later than twenty-four (24) hours after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting the claim. This notice may be oral unless written notice is requested by the Claimant.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

- (ii) *Pre-service Health Benefit Claims.* For a pre-service health benefit claim, the Reviewer will notify the Claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within fifteen (15) days after the Plan receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its

decision beyond thirty (30) days after receiving the claim. However, if an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

If any person fails to follow the Plan's procedures for submitting a pre-service health benefit claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific Participant or Dependent, a specific medical condition or symptom and a specific treatment, service, or product for which approval is requested; the Plan Administrator or Reviewer will notify the potential Claimant as soon as possible but no later than five (5) days after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting a pre-service claim. The notice may be oral unless written notice is requested by the Claimant.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- (iii) *Post-service Health Benefit Claims.* For a post-service health benefit claim, the Reviewer will notify the Claimant of the Plan's Adverse Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. If, due to matters beyond the control of the Plan, the Reviewer needs additional time to process a claim, the Claimant will be notified, within thirty (30) days after the Reviewer receives the claim, of those circumstances and of when the Reviewer expects to make its decision. Under no circumstances may the Reviewer extend the time for making its decision beyond forty-five (45) days after receiving the claim. However, if such an extension is necessary because the Claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant will be afforded at least forty-five (45) days from receipt of the notice to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services which the Claimant has already received.

- (iv) *Concurrent Care Claims.* Notwithstanding any other provision of this Article, if the Plan has previously approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the

approved time period or number of treatments will constitute an adverse initial benefit determination. These determinations will be known as “concurrent care” decisions. The Reviewer will notify the Claimant of an adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

Any request by a Claimant to extend a course of urgent care treatment beyond the approved period of time or number of treatments will be decided as soon as possible, taking into account the medical exigencies, and the Reviewer will notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after the Plan receives the claim, provided that the claim is submitted at least twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments.

- (c) *Disability Benefit Claims.* If a claim for disability benefits is denied, in whole or in part, the Claimant will receive a written notice from the Reviewer within a reasonable period of time, but no later than 45 days after it receives the claim. Under special circumstances, the Reviewer may take up to an additional 30 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. If, prior to the end of the first 30-day extension period, the Reviewer determines that an additional extension is necessary due to matters beyond its control, the Reviewer may take up to an additional 30 days to review the claim. If an additional extension of time is required, the Claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. If the Reviewer extends its period for reviewing a claim due to special circumstances, the notice of extension the Claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The Claimant has at least 45 days to provide the specified information.
- (d) *Manner and Content of Denial of Initial Claims.* If the Reviewer denies a claim, it will provide to the Claimant a written or electronic notice that includes:
 - (1) A description of the specific reasons for the denial;
 - (2) A reference to any Plan provision or insurance contract provision upon which the denial is based;

- (3) A description of any additional information or material that the Claimant must provide in order to perfect the claim;
- (4) An explanation of why such additional material or information is necessary;
- (5) A statement that the Claimant has a right to request a review of the claim denial and information on the steps to be taken if the Claimant wishes to request a review of the claim denial; and
- (6) If applicable, a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following a denial on review of the initial denial.

In addition, for a denial of a claim for health benefits or disability benefits, the following must be provided:

- (7) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the Claimant and without charge); and
- (8) If the adverse determination is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the Claimant's medical circumstances or a statement that an explanation will be provided upon request and without charge.

For any Adverse Determination concerning an urgent care health claim, the information described in this Section may be provided to the Claimant orally within the permitted time frame, provided that a written or electronic notice in accordance with this Section is furnished not later than three (3) days after the oral notice.

- (e) *Manner and Content of Denial of Initial Disability Claims.* In addition to the requirements set forth in section (d) above, the following provisions shall apply to disability benefit claims filed under the Plan:

- (1) If a Reviewer denies a disability claim, the written or electronic notice provided to the Claimant shall also include the following information:
 - (i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (b) the views of medical or vocational experts whose advice was

obtained on behalf of the plan in connection with a Claimant's Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and

- (ii) 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 Claimant's claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to Section 2560.503-1(m)(8) of the ERISA Regulations.
 - (iii) A statement that prior to issuing any Adverse Determination on review of a disability benefit claim:
 - (a) The Plan Administrator shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination on review is required to be provided (as described in paragraph (c) above) to give the Claimant a reasonable opportunity to respond prior to the date; and
 - (b) If such Adverse Determination is based on a new or additional rationale, the Plan Administrator shall provide the Claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination on review is required to be provided under paragraph (c) above to give the Claimant a reasonable opportunity to respond prior to that date.
- (2) Any notice of Adverse Determination provided with respect to disability benefits shall be provided in a culturally and linguistically appropriate manner.

10.3 Review Procedures

- (a) *Non-Health and Non-Disability Benefit Claims.* A request for review of a denied claim for a benefit other than health or disability benefits must be made in writing to the Reviewer within sixty (60) days after receiving notice of denial. The decision upon review will be made within sixty (60) days after the Reviewer receives the request for review, unless special circumstances require an extension of time for

processing, in which case a decision will be rendered not later than one hundred twenty (120) days after the request for review is received. A notice of such an extension must be provided to the Claimant within the initial sixty (60) day period and must explain the special circumstances and provide an expected date of decision.

The Reviewer will afford the Claimant an opportunity to review and receive, without charge, all relevant documents, information, and records and to submit issues and comments in writing to the Reviewer. The Reviewer will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

- (b) *Health Benefit Claims.* A request for review of a denial of an initial claim for health benefits must be submitted in writing to the Reviewer no later than one hundred eighty (180) days after the Claimant receives the notice of denial of the initial claim.

Notwithstanding the preceding, following a denial of an initial urgent care health benefits claim, the Claimant may request an expedited review of the claim and such a request may be submitted orally or in writing at the discretion of the Claimant. If an expedited review is requested, all necessary information, including the plan's benefit determination on review, will be transmitted between the Reviewer and the Claimant by telephone, facsimile, or other available similarly expeditious method, whenever possible.

In addition to providing the Claimant the right to review documents and submit comments as described in (a) above, a review of a denial of a health benefits claim will meet the following requirements:

- (i) The Plan will provide a review that does not afford deference to the initial Adverse Determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal and who is not a subordinate of the individual who made the determination.
- (ii) The appropriate named fiduciary of the Plan will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. The professional engaged for purposes of a consultation described in the preceding sentence will be an

individual who was not consulted in connection with the initial determination that is the subject of the appeal, nor the subordinate of any such individual.

- (iii) The Plan will identify to the Claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the review, without regard to whether the advice was relied upon in making the benefit review determination.
- (iv) For purposes of any Benefit Package Option that is subject to PPACA, the Plan or Insurer will allow a Claimant to review the claim file and to present evidence and testimony as part of its internal claims and appeals process.
- (v) For purposes of any benefit option that is subject to PPACA that is not a Grandfathered Plan, the Plan or Insurer will comply with the following requirements:
 - (1) The Plan or Insurer will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or Insurer in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided under this Article (and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date; and
 - (2) Before the Plan or Insurer issues a final internal Adverse Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale for its decision as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is to be provided under this Article (and applicable Regulations) to give the Claimant a reasonable opportunity to respond before that date.

(c) *Deadline for Review Decisions.*

- (i) *Urgent Health Benefit Claims.* For urgent care health claims, the Reviewer will notify the Claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Plan receives the Claimant's request for review of the initial adverse determination.
- (ii) *Other Health Benefit Claims.*

- (1) For a pre-service health claim, the Reviewer will notify the Claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than thirty (30) days after the Plan receives the Claimant's request for review of the initial adverse determination.
 - (2) For a post-service health claim, the Reviewer will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than sixty (60) days after the Plan receives the Claimant's request for review of the initial adverse determination.
- (d) *Disability Benefit Claims.* A request for review of a denial of an initial claim for disability benefits must be submitted in writing to the Reviewer no later than one hundred eighty (180) days after the Claimant receives the notice of denial of the initial claim. The request must be submitted in writing and must include:
- (i) the reasons why the Claimant feels the claim is valid; and
 - (ii) the reasons why the Claimant thinks the claim should not be denied.

Documents, records, written comments, and other information in support of the appeal should accompany the request. This information will be considered by the Reviewer in reviewing the claim. The Claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. The Reviewer will review the claim without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person who was involved in making the initial decision regarding the claim, or subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the Reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person or a subordinate of a person consulted by the Reviewer in deciding the initial claim.

The Reviewer will notify the Claimant of its decision on the appeal within 45 days after receipt of the appeal. Under special circumstances, the Reviewer may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the Claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Reviewer expects to render a decision. The Claimant has at least 45 days to provide the specified information

- (e) *Manner and Content of Notice of Decision on Review of Non-Disability Benefit Claims.* Upon completion of its review of an initial Adverse Determination, the Reviewer will provide the Claimant written or electronic notice of its decision on review. For any Adverse Determination on review, that notice will include:
- (i) a description of its decision;
 - (ii) an explanation of the specific reasons for the decision;
 - (iii) a reference to any relevant Plan provision or insurance contract provision on which its decision is based;
 - (iv) a statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the Claimant's claim for benefits;
 - (v) if applicable, a statement describing the Claimant's right to bring an action for judicial review under ERISA Section 502(a);

In addition, for a denial of an appeal for health benefits or disability benefits, the following must be provided:

- (vi) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the Claimant upon request; and
- (vii) if the adverse determination on review is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that an explanation will be provided without charge upon request.

Also, upon request, the Reviewer will provide the Claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

- (e) *Manner and Content of Notice of Decision on Review of Disability Benefit Claims.* In addition to the requirements set forth in section (e) above, the following provisions shall apply to notices of decision on review of disability benefit claims filed under the Plan:
- (i) Upon completion of its review of an initial Adverse Determination, the Reviewer will provide the Claimant written or electronic notice of its

decision on review. For any Adverse Determination on review, that notice will include:

- (1) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claimant's Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration; and
 - (2) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the Adverse Determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.
- (ii) In the case of an Adverse Determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

10.4 Adverse Determination

For purposes of this Article, an Adverse Determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a Benefit Package Option, and including, with respect to any group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. For purposes of any benefit package that is subject to PPACA but is not a Grandfathered Plan, Adverse Determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission. For purposes of disability benefit claims filed under the Plan, an Adverse Determination also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

10.5 Additional Notice Requirements

For any Adverse Determination involving coverage that is subject to PPACA that is not a Grandfathered Plan, any notice of Adverse Determination will include (in addition to other requirements described in this Article):

- (a) information sufficient to identify the claim involved;
- (b) notification of the opportunity to request the diagnosis and treatment codes associated with the claim involved, including their respective meanings, and to have such information provided upon request;
- (c) a description of available internal appeals and external review processes, including information regarding the time limits applicable to such procedures and how to initiate an external appeal; and
- (d) contact information for any applicable office of health insurance consumer assistance or ombudsmen established pursuant to PPACA to assist individuals with internal claims and appeals and external review processes.

Any Adverse Determination regarding coverage that is subject to PPACA that is not a Grandfathered Plan will be provided in a culturally and linguistically appropriate manner in accordance with applicable Regulations or other authoritative guidance regarding such notices.

10.6 Additional Provisions Applicable to Health Benefit Claims

- (a) *Failure to Establish and Follow Reasonable Claims Procedures.* With respect to claims for health benefits filed under the Plan, if the Plan fails to establish and follow reasonable claims procedures, the following is applicable:
 - (i) A Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.
 - (ii) Notwithstanding the preceding paragraph, administrative remedies will not be deemed exhausted where the violation is: (i) *de minimis*; (ii) non-prejudicial with respect to the Claimant; (iii) for good cause or due to matters beyond the Plan's control; (iv) in the context of an ongoing, good faith exchange of information; and (v) not part of a pattern or practice of violations by the Plan.
 - (iii) The Claimant may request a written explanation of any violation described in this Section 10.6(a). Such explanation must be provided by the Plan

within 10 days, and must include a specific description of its bases, if any, for asserting that administrative remedies should not be deemed exhausted.

- (iv) If a court rejects the Claimant's request for immediate review on the basis that the Plan satisfied the requirements for providing a reasonable claims procedure, the claim shall be considered re-filed on appeal upon the Plan's receipt of the court's decision, and the Plan shall provide Claimant with a notice of the resubmission within a reasonable period of time.

10.7 Additional Provisions Applicable to Disability Benefit Claims

- (a) *Failure to Establish and Follow Reasonable Claims Procedures.* With respect to claims for disability benefits filed under the Plan, if the Plan fails to establish and follow reasonable claims procedures, the following is applicable:
 - (i) A Claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.
 - (ii) Notwithstanding the preceding paragraph, administrative remedies will not be deemed exhausted where the violation is: (i) *de minimis*; (ii) non-prejudicial with respect to the Claimant; (iii) for good cause or due to matters beyond the Plan's control; (iv) in the context of an ongoing, good faith exchange of information; and (v) not part of a pattern or practice of violations by the Plan.
 - (iii) The Claimant may request a written explanation of any violation described in this Section 10.7(a). Such explanation must be provided by the Plan within 10 days, and must include a specific description of its bases, if any, for asserting that administrative remedies should not be deemed exhausted.
 - (iv) If a court rejects the Claimant's request for immediate review on the basis that the Plan satisfied the requirements for providing a reasonable claims procedure, the claim shall be considered re-filed on appeal upon the Plan's receipt of the court's decision, and the Plan shall provide Claimant with a notice of the resubmission within a reasonable period of time.

10.8 Impartiality

With respect to all claims for benefits filed under the Plan, the Plan or Insurer will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

10.9 Calculation of Time Periods

For purposes of the time periods specified in this Article, the period of time during which a benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a period of time is extended because a Claimant fails to submit all information necessary for a claim for non-urgent care health benefits, the period for making the determination will be tolled from the date the notification is sent to the Claimant until the date the Claimant responds or, if earlier, until forty-five (45) days from the date the Claimant receives (or was reasonably expected to receive) the notice requesting additional information.

10.10 Failure of Claimant To Follow Procedures

A Claimant's compliance with the foregoing provisions of this Article is a mandatory prerequisite to the Claimant's right to commence any legal action with respect to any claim for Benefits under the Plan.

10.11 Preemption of State Law

For any insured benefit under this Plan, nothing in this Article shall be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of this Article.

10.12 Voluntary External Review

If a claimant is enrolled in a medical Benefit subject to the ACA that is not subject to a State external review process, then upon exhausting the internal group health plan claim and appeal procedures described in Section 10.2 and Section 10.5 (or earlier, if the claimant is deemed to have exhausted such procedure due to the Plan's failure to comply with the procedure) with respect to any claim that involves medical judgment or rescission of coverage, the claimant may request an external (i.e., independent) review of the adverse benefit determination or final internal adverse benefit determination within four months after receiving the notice of denial or review determination notice.

Within five business days after receiving a claimant's request, a preliminary review will be completed to determine whether: (i) the claimant is/was covered under the Plan; (ii) the denial was based on an issue involving medical judgment or a rescission of coverage; (iii) the claimant exhausted the Plan's internal claim and appeal process, if required; and (iv) the claimant provided all information necessary to process the external review. Within one business day after completing the preliminary review, the claimant will be notified in writing if his or her request is not eligible for an external review or if it is incomplete. If the claimant's request is complete but not eligible, the notice will include the reason(s) for ineligibility. If the claimant's request is not complete, the notice will describe any information needed to complete the request. The claimant will have the remainder of the four-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, the claimant's request will be assigned to an

independent review organization (“IRO”). The IRO will provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, a claimant has the right to an expedited external review in the following situations:

- (a) Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant’s life or health or would jeopardize his or her ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
- (b) Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant’s life or health or would jeopardize his or her ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.
- (c) The IRO will provide notice of its final external review decision as expeditiously as the claimant’s medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

ARTICLE XI

Miscellaneous

11.1 In General

Any and all rights of benefits accruing to any person under the Plan shall be subject to all terms and conditions of the Plan. The adoption and maintenance of the Plan shall not constitute a contract between a Participating Employer and any Employee.

11.2 Nonalienation of Benefits

Except as otherwise expressly provided under the terms of any Related Document, or except as may otherwise be required by law, a Participant's rights, interests, and Benefits under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, garnishment, execution, encumbrance, or charge of any kind, whether voluntary or involuntary, and any attempt to do so shall be void. If any person entitled to Benefits under the Plan becomes bankrupt or attempts to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any Benefit under the Plan, or if any attempt is made to subject any such Benefit to the debts, contracts, liabilities, liens, or torts of the person entitled to any such Benefit, except as specifically provided in the Plan, then such Benefit shall cease and terminate in the discretion of the Plan Administrator, and the Plan Administrator may hold or apply the amount of such Benefit or any part thereof to the benefit of any dependent of such person, in such manner and proportions as the Plan Administrator may deem proper.

As a matter of convenience, the Plan may provide health benefits on behalf of Covered Individuals by paying their respective health care providers directly rather than requiring such Covered Individuals to first pay the provider and then request reimbursement from the Plan. However, such providers shall not be considered Covered Individuals or Plan participants or beneficiaries for any Plan purpose.

11.3 No Employment Rights

Nothing contained in the Plan shall be construed as a contract of employment between a Participating Employer and any Employee or other person, as a right of any Employee or other person to be continued in the employment of a Participating Employer, or as a limitation of the right of a Participating Employer to discharge any of its Employees or other workers with or without cause.

11.4 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof shall be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator or any Participating Employer, except as expressly provided herein and by applicable law.

11.5 Discrimination Prohibited

If the County determines, before or during any Plan Year, that any component benefit plan under the Plan may fail to satisfy any nondiscrimination requirement or other limitation which is imposed by the Code on such plan, in accordance with applicable Code provisions and regulatory guidance thereunder, the County may (to the maximum extent permitted under the Code) designate two or more separate Benefit Package Options of the same type (e.g., group health plans, group life insurance plans, or cafeteria plans) as constituting a single plan, or, alternatively, may restructure any component benefit plan under the Plan into multiple Benefit Package Options of the same type for testing purposes (each of which shall constitute a separate plan for relevant Code purposes). The Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements or limitations.

11.6 Filing of Information

Each Eligible Employee or other interested person shall file with the Plan Administrator such pertinent information concerning himself or herself as the Plan Administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan Administrator may specify or provide, and such person shall not have right or be entitled to any Benefits or further Benefits hereunder the Plan unless such information is filed by him or her or on his or her behalf.

11.7 Addresses; Notices; Waivers of Notice

Each Participant must file with the Plan Administrator, in writing, his or her post office address and any change of post office address. Any communication, statement, or notice addressed to such Participant at his or her last post office address as filed with the Plan Administrator will be binding upon the Participant for all purposes of the Plan, and neither the Plan Administrator nor any Participating Employer shall be obliged to search for or ascertain the whereabouts of any Participant.

11.8 Mistake of Fact

Any mistake of fact or misstatement of fact may be corrected by the Plan Administrator when it becomes known, and the Plan Administrator may make such adjustment as it considers equitable and practical.

11.9 No Waiver or Estoppel

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a

waiver of such term or condition for the future or as to any act other than that specifically waived.

11.10 Limitation on Actions

Unless provided for otherwise in the applicable Related Document, no action at law or in equity shall be instituted to recover under the Plan until the Participant has first exercised all claims and appeal rights provided for by the Plan or Related Document and only if there has been an adverse determination made on appeal regarding the Participant's request for Benefits. Furthermore, such action must be instituted within one year following the adverse determination on appeal, or in the event that the Plan Administrator or its representative fails to timely resolve a Participant's timely appeal, within one year following the final date that the Plan Administrator or its representative should have resolved such appeal. Any claim not commenced within such one-year period shall be forever waived.

11.11 Employee Authorization of Payroll Deductions

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, ERISA or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted. By using electronic media, an Employee consents to (a) deductions from his or her Compensation in accordance with his or her elections made through the system, and (b) the recording of his or her telephone call on the voice response system.

11.12 Reclassification

This Section 11.12 applies to any individual who is classified by any Participating Employer as a leased employee, independent contractor or as coming within another non-Employee or ineligible designation. If any such individual is thereafter required by the Internal Revenue Service, U.S. Department of Labor or other government agency, or by any court or other tribunal, to be classified as an Employee, such individual shall not be eligible to participate in this Plan unless and until the time he or she is designated by the Plan Administrator as an Eligible Employee. Such designation shall only provide for eligibility prospectively from the time it is made.

11.13 No Guarantee of Tax Consequences

Neither any Participating Employer nor the Plan Administrator makes any warranty or other representation as to whether any payment received under the Plan will be treated as excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from his or her gross income for such purposes and to notify the Plan Administrator immediately if the Participant has any reason to believe that any such payment is not so excludable.

11.14 Quality of Health Services

The selection by the County of the coverage that may be financed through the Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services that may be provided by any dental, health or prescription drug service provider, nor does the County assume or accept any responsibility with respect to the denial by any prospective provider of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances. Each Employee for whom enrollment is provided under any coverage agrees, as a condition of such enrollment, that such Employee will look only to appropriately certified or licensed providers, and not to the County, for Benefit related services, and further that the Employee releases, discharges, indemnifies, and holds harmless the County, the Plan Administrator, their respective employees, officers, directors, and shareholders, and all other persons associated with them, with respect to all matters relating to (a) the quality, sufficiency, and appropriateness of dental, health, or prescription drug services provided, (b) the failure by any provider to provide any service needed, or to properly obtain informed consent prior to rendering or withholding any service, regardless of the reason for such failure, and (c) professional malpractice by a service vendor or provider, or the failure of any insurance carrier to pay for any care for which the Employee or other service recipient believes himself or herself entitled to reimbursement.

11.15 Insurance Contracts

The County has the right to enter into contracts with one or more insurance companies for the purpose of providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant or eligible dependent may look only to the insurance company for payment of that benefit.

Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contracts used to provide Benefits shall be the property of, and shall be retained by, the Employer, except to the extent, if any, that the Plan Administrator determines that a portion of the payment is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets.

11.16 Governing Law

The Plan shall be construed and enforced in accordance with the internal laws (excluding provisions and principles of conflict of laws) of the State of Georgia (except as otherwise specified in a Related Document with respect to Benefits governed thereby).

11.17 Gender and Form

Words used in the Plan in the masculine gender shall be construed as though they also are used in the feminine gender in all situations where they would apply. Words used in the Plan in the singular form shall be construed as though they also are used in the plural form in all situations where they would apply, and vice versa.

11.18 Captions and Headings

The caption or heading of an article, section or provision of the Plan is for convenience and reference only and shall not to be considered in interpreting the terms and conditions of the Plan.

11.19 Severability

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

11.20 Plan Interpretation

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator in its sole discretion in accordance with Section 7.2. The Plan shall be amended retroactively to cure any such ambiguity. Neither this Section, Section 7.2, nor any other Plan provision may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Plan Administrator.

11.21 Conflicting Provisions of Related Documents

Notwithstanding any provision of the Plan, the provisions in the materials that are incorporated by reference in the Plan to form and constitute the Related Documents shall apply in all cases. The provisions of the Plan shall be interpreted to apply in conjunction with and in addition to such provisions. In the event of a direct conflict between the provisions of a Related Document and the provisions of the Plan, the provisions of the Plan shall prevail. Where terms and provisions specifically applicable to an individual Related Document are not addressed in the Plan document, such terms and provisions as set forth in such Related Document will govern.

11.22 Legal Service

Process in legal actions regarding a claim for Benefits shall be directed to the applicable Provider or Claims Administrator. Process in all other legal actions concerning the Plan shall be directed to the County.

11.23 Plan Records

All Plan records shall be kept on a Plan Year basis.

11.24 Indemnification

To the maximum extent permitted by law, each Participating Employer shall defend, indemnify, and hold harmless any director, officer, employee, or agent of such County from and against any and all claims, losses, damages, expenses, costs, and liabilities (collectively “Loss”) arising from any act or failure to act that constitutes or is alleged to constitute a breach of such person’s responsibilities in connection with the Plan under ERISA or any other law, unless such Loss is determined to be due to such person’s gross negligence or willful misconduct.

11.25 Bonding and Insurance

To the extent required by ERISA or other applicable law with respect to Benefits subject to ERISA, every fiduciary of the Plan, including any Related Document, and every person handling funds of the Plan or such component thereunder shall be bonded. The Plan Administrator may apply for and obtain fiduciary liability insurance insuring the Plan against damages by reason of breach of fiduciary responsibility at the Plan’s expense and insuring each fiduciary against liability to the extent permissible by law at the County’s expense.

11.26 Qualified Medical Child Support Order

The Plan Administrator shall comply with the terms of a QMCSO.

11.27 Complete Statement of Plan

The Plan supersedes all prior plans governing the types of Benefits provided under the Plan. This document, including the Related Documents, contains a complete statement of the terms of the Plan. The right of any person to any benefit of a type provided under the Plan shall be determined solely in accordance with the terms of the Plan. No other evidence, whether written or oral, shall be taken into account in determining the right of any person to any benefit of a type provided under the Plan.

11.28 Single Document

This document, including the Related Documents identified in Appendix B, legally governs the operation of the Plan and shall be treated as a single employee welfare benefit plan for purposes of ERISA.

11.29 Venue

The exclusive venue for all disputes arising out of and relating to the Plan is in any court of appropriate jurisdiction located in the State of Georgia.

11.30 Mental Health Parity

Notwithstanding any provision of the Plan to the contrary, mental health and substance abuse benefits provided under any Medical/Prescription Drug Plan Benefit Package Option will comply in all respects with the MHPAEA.

11.31 GINA

Notwithstanding any provision of the Plan to the contrary, the Plan, including all Medical/Prescription Drug Plan Benefit Package Options, will comply with the requirements of GINA.

11.32 Health Care Reform

A group health plan Benefit Package Option that is not exempt or an excepted benefit, as defined in ERISA Section 732, shall comply with the applicable group market (insurance) reforms that apply to a group health plan under PPACA.

- (a) As explained in ERISA Section 715, the PPACA group market (insurance) reforms that apply to all group health plan Benefit Package Options under the Plan that are not exempt or excepted benefits under ERISA Section 732 are:
 - (i) Prohibition of preexisting condition exclusions under PHSA Section 2704 and ERISA Regulation Section 2590.715-2704;
 - (ii) Prohibiting discrimination against participants and beneficiaries based on a health factor under PHSA Section 2705 and ERISA Regulation Section 2590.715-2705;
 - (iii) Prohibition on waiting periods that exceed 90 days under PHSA Section 2708 and ERISA Regulation Section 2590.715-2708;
 - (iv) Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA Section 2711 and ERISA Regulation Section 2590.715-2711;
 - (v) Prohibition on rescissions under PHSA Section 2712 and ERISA Regulation Section 2590.715-2712;

- (vi) Eligibility of children until at least age 26 under PHSA Section 2714 and ERISA Regulation Section 2590.715-2714;
 - (vii) Summary of benefits and coverage and uniform glossary under PHSA Section 2715 and ERISA Regulation Section 2590.715-2715; and,
 - (viii) Solely with respect to insured Benefit Options, the medical loss ratio requirements under PHSA Section 2718.
- (b) As explained in ERISA Section 715 and related regulatory and subregulatory guidance, PPACA group market (insurance) reforms that apply to group health plan Benefit Package Options that have lost Grandfathered Plan status (or which never attained Grandfathered Plan status) and are not exempt or excepted benefits under ERISA Section 732 are:
- (i) Accommodations in connection with coverage of preventive health services under PHSA Section 2713 and ERISA Regulation Section 2590.715-2713A;
 - (ii) Internal claims and appeals and external review process as discussed under PHSA Section 2719 and ERISA Regulation Section 2590.715-2719;
 - (iii) Consumer patient protections (prevention of surprise medical bills, choice of health care professional and coverage of emergency services) under PHSA Sections 2799A-1, 2799A-2, 2799A-7, and ERISA Regulation Sections 2590.716-3, 2590.716-4, 2590.716-5, 2590.717-1, and 2590.722;
 - (iv) Provider non-discrimination under PHSA Section 2706(a);
 - (v) Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA Section 2707(b); and,
 - (vi) Coverage for individuals participating in approved clinical trials under PHSA Section 2709.

While not referenced in this Plan document, the Benefit Package Options that are subject to the group market (insurance) reforms will comply with respect to both regulatory and subregulatory guidance. To the extent that the U.S. Department of Labor, Internal Revenue Service or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by PPACA, the Plan shall comply to the extent necessary.

11.33 COVID-19 Relief

As required by the Families First Coronavirus Response Act (FFCRA) as amended by the CARES Act, the Plan will provide coverage for COVID-19 diagnostic testing at no cost to the participant (i.e., no deductible, copayment, or coinsurance). The “cost of testing” includes the cost of the health care provider office visits, urgent care center visits, and emergency room visits to the extent that the item or service relates to the furnishing or administration of the “COVID-19 test” or an evaluation for purposes of determining if a diagnostic test is needed.

The Plan will also cover, without cost sharing, both the COVID-19 vaccination and its administration, by both in-network and out-of-network providers, as recommended by the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Also covered are other qualifying coronavirus preventive items and services as they are recommended.

These requirements shall expire upon the expiration of the Public Health Emergency, as previously initiated by the Secretary of Health and Human Services.

11.34 Rescission of Coverage

Notwithstanding any provision of the Plan to the contrary, the Plan may rescind coverage under any Benefit Package Option for any individual (or a Participant or Dependent covered under the same coverage as that individual) who engages in fraud with respect to the Plan, or who makes an intentional misrepresentation of material fact. Except as otherwise prohibited by law, the Plan may rescind coverage under a Benefit Package Option for other reasons in accordance with the terms of the applicable Benefit Package Option.

The Plan will not rescind coverage under any Benefit Package Option that is subject to PPACA, for any individual covered under that Benefit Package Option, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be rescinded under this Section. This paragraph is included in the Plan to comply with the requirements of PPACA and applicable regulations, including Treasury Regulations Section 54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

For purposes of this Section, a rescission is a cancellation or discontinuance of coverage under a Benefit Package Option that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if it is effective retroactively only to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage.

IN WITNESS WHEREOF, the Chatham County Health & Welfare Benefits Policy is, executed on behalf of the County, this 14th day of July, 2023.

By: Michael C. Layler
Name

Its: County Manager
Title

APPENDIX A

Participating Employers

Participating Employers

Chatham County Family Justice Center

Chatham County Safety Net Planning Council

Coastal Georgia Indicators Coalition

Live Oak Public Libraries

Separation Agreements

MOUs - Chatham County occasionally enters into intergovernmental agreements and Memorandums of Understanding (MOUs) with local partners. These agreements and partnerships sometimes allow participation in one or more Chatham County Benefit Plans. Each agreement is unique and requires the signature of the County Manager and/or Chairman of the Board of Commissioners. A digest of these agreements is kept on file, and administered by the Benefits Manager, under supervision of the Director of Human Resources.

APPENDIX B

Related Documents

The Plan incorporates the following Related Documents to describe the provisions of the Plan in greater detail. All obligations of the Plan Administrator, Provider, Claims Administrator and/or a Participating Employer described in the Plan extend by reference to the Related Documents.

MEDICAL / PRESCRIPTION DRUG (Including Chatham County Employee Health Center)	Anthem Group #GA7387 Marathon Health
PRE-65 RETIREE MEDICAL/PRESCRIPTION DRUG	Anthem Group #GA7387
MEDICARE ADVANTAGE	UnitedHealthcare Policy #25378
DENTAL (Including Retiree Dental)	United Concordia Policy #200447
VISION (Including Retiree Vision)	Anthem Group #GA7387
LIFE/AD&D (Including Supplemental, Dependent and Retiree Life)	Met Life Policy #122344-1-G
LONG-TERM DISABILITY	The Hartford Policy #GLT-402962
EMPLOYEE ASSISTANCE PROGRAM (EAP)	Performance Management Resources
FLEXIBLE SPENDING ACCOUNTS (Including Health and Dependent Care)	Ameriflex Group #AMFCHATHA
VOLUNTARY BENEFITS (Including Accident, Cancer, Critical Illness, Short-term Disability, Hospital Confinement, Whole Life and Universal Life Insurance)	Colonial Life Insurance (Individual Policies)
GROUP LEGAL	Hyatt Legal Group #990-2441 & 990-2442
WELLNESS PLAN	Employee Health Center
RETIREE BENEFITS (In general)	Chatham County Pension Plan
BENEFITS while on unpaid Leave	Chatham County Policy for Benefits Continuation While on Unpaid Leave
PROOF OF ELIGIBILITY	Chatham County Dependent Eligibility Verification form.