LUCAS COUNTY

PRESCRIPTION DRUG BENEFIT PLAN

AS AMENDED AND RESTATED

EFFECTIVE MARCH 1, 2011

Board of County Commissioners, Lucas County, Ohio
Employee Benefits
One Government Center, Suite 440
Toledo, Ohio 43604-2259

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PURPOSE OF THE PLAN

The Board of County Commissioners, Lucas County, Ohio adopts this document, including any addenda, to maintain a prescription drug benefit plan for the exclusive benefit of its Eligible Employees and their Eligible Dependents and the Eligible Employees and their Eligible Dependents of eligible designated entities.

PLAN ADMINISTRATION

The Plan is self-administered by the Plan Administrator; however, the Plan Administrator has engaged the services of the Claims Administrator to handle the day-to-day operation of the Plan and has purchased stop-loss insurance to pay large, single claims incurred in any Plan Year in which the claim(s) may exceed an expected amount. The Plan's administrative costs are borne by the Plan Sponsor.

ERISA COMPLIANCE

This plan is a 'governmental plan' as defined by ERISA Section 29 USC §1002 (32) and is exempt from the provisions of United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191(c). Adoption or use of a term or procedure in the Plan that is identical or substantially similar to a term or procedure contained in 29 USC §1001 through 29 USC 1191(c) shall not cause the plan to lose its 'governmental plan' exemption.

GENERAL COMMENTS PERTAINING TO ELIGIBLITY

Non-Bargaining Unit Employees. The Plan Sponsor reserves the right at its sole discretion to modify, suspend, or terminate the eligibility rules contained in Article 2.0, herein and/or any or all provisions contained herein with or without notice. The Plan Administrator is the sole arbiter of the eligibility rules. The eligibility rules are not a contract, express or implied. No representative of the Plan Sponsor, or any other Lucas County agency, board, department or official, has the authority to enter into an agreement with an employee or employee representative that provides any benefit greater than the benefits set forth in these rules. There is no guarantee of eligibility or coverage for any agreement made contrary to these rules.

Collective Bargaining Unit Employees. The eligibility rules contained in Article 2.0, herein shall be subject to labor contract negotiations between the Plan Sponsor and the various unions representing Lucas County, Ohio employees. It is in the best interest of all parties that there be only one health insurance benefit package for all Lucas County, Ohio employees. Therefore, these eligibility rules shall be discussed and reviewed at meetings of the Lucas County Health Care Cost Containment Board.

ARTICLE 1.0

DEFINITIONS

The following terms used in this Plan document shall have the following meanings. Use of a term in this document that is identical to, or having substantially the same meaning as, the same term in 29 USC §1002 shall not constitute, or be interpreted as, either a waiver or other revocation of the Plan's status as a 'governmental plan' as defined under 29 USC §1002(32), or a waiver or other revocation of the Plan's 29 USC §1003(b)(1) exemption from the provisions of ERISA contained in United States Code Title 29, Chapter 18, Subchapter I (29 USC §1001 through 29 USC §1191c).

1.01 **"Actively at Work".** An Employee's actual engagement in employment at an Employer's business establishment, or at other locations that the Employer may require the Employee to travel to and work at, for which the Employee is eligible to receive, or actually receiving, Pay.

1.02 **"Active Pay Status".** The conditions under which an Employee is receiving Pay from his Employer.

1.03 **"Active Work Status".** Conditions under which an Employee is employed by an Employer but not actually receiving Pay.

1.04 **"Adopting Employer".** Any of the following entities (other than the Plan Sponsor) which have adopted this Plan for the benefit of their Employees:

Board of Lucas County Commissioners (Human Resources, Support Services, OMB, Administration, Commissioners, Facilities, Building Regulations, Child Support Enforcement Agency, Dog Warden, Emergency Services, Job and Family Services, Maumee River Wastewater Treatment Plant, Sanitary Engineer, Solid Waste Management and Workforce Development.)
Criminal Justice Coordinating Council
Lucas County Auditor
Lucas County Board of Developmental Disabilities
Lucas County Board of Elections
Lucas County Children Services
Lucas County Clerk of Courts
Lucas County Common Pleas Court
Lucas County Coroner
Lucas County Domestic Relations Court
Lucas County Engineer

Lucas County Family Council
Lucas County Juvenile Court
Lucas County Law Library
Lucas County Mental Health & Recovery Services Board
Lucas County Probate Court
Lucas County Prosecutor
Lucas County Recorder
Lucas County Sheriff
Lucas County Soil & Water Conservation District
Lucas County Treasurer
Lucas County Veteran Service Commission
Metropolitan Park District of Toledo Area
Olander Park District
Toledo-Lucas County Health Department

1.05 **"Allowable Expenses".** The submitted charges that are considered Covered Expenses under Article 4.0, "Schedule of Benefits"..

1.06 "**Appeals Committee".** The entity established by the Claims Administrator to review and rule on appeals of the Claims Administrator's denial of benefits and/or coverage submitted by Participants and/or Providers. The address of the Appeals Committee is:

LUCAS COUNTY EMPLOYEE BENEFITS
One Government Center, Suite 440
Toledo, OH 43604 (419) 213.4531

1.07 "**Authorized Medical Leave of Absence".** An Employee's leave of absence for medical reasons as approved by the Employee's Employer. An Authorized Medical Leave of Absence does not include a leave of absence granted for workers' compensation purposes.

1.08 **"Benefit Percentage".** That portion of Covered Expenses in excess of any applicable Co-payment that is to be paid in accordance with Section 4.03, "Schedule of Benefits", hereinbelow subject to the Plan's designated maximum benefit amounts.

1.09 **"Benefit Period".** An annual time period commencing on March 1 of each Plan Year. The Benefit Period will terminate on the earliest of the following dates:

(A) the last day of February of the same Plan Year in which the Benefit Period

commenced; or

(B) the day the Participant ceases to be a Participant under this Plan.

1.10 "**Child" or "Children".** An individual who is a:

(A) biological child of the Employee;

(B) stepchild of the Employee (except in the case of the child of a domestic Partner who is a Spouse);

(C) legally-adopted child of the Employee; or

(D) a child not described in Section 1.10(A), (B) or (C) hereinabove, but for whom the Employee and/or his Spouse is/are the court-ordered guardian(s) or court-ordered custodian(s) provided the court-ordered custody or guardianship has not been granted solely for the purpose of qualifying the child for coverage under the Plan.

The Plan Administrator may require the Employee to submit Documentation demonstrating, to the sole satisfaction of the Plan Administrator, that the individual claimed to be the Employee's and/or Spouse's Child meets the requirements of paragraph (A), (B), (C) or (D), of this Section 1.10.

1.11 **"Claim Determination Period".** A Plan Year or that portion of a Plan Year during which the Participant for whom a claim is made has been covered under this Plan.

1.12 **"Claims Administrator".** The individual or business entity, if any, selected and retained by the Plan Administrator to supervise the administration, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written administration agreement. If no Claims Administrator is appointed or retained (as a result of the termination or expiration of the administrative agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Claims Administrator in writing, the term will mean the Plan Administrator.

The entity retained by the Plan Administrator to serve as the Claims Administrator of the Plan is:

TOTAL SCRIPT, INC.
10901 W. 120th Avenue, Suite 175
Broomfield, CO 80021 (800)752.2211

1.13 **"Close Relative".** The Spouse, parent, brother, sister, or Child of an Employee-Participant or the parent, brother, sister or Child of an Employee-Participant's Spouse.

1.14 **"COBRA".** The health insurance continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 added to Title XXII of the Public Health Service Act at 42 USC §300bb-1 et.seq. as amended from time to time.

1.15 **"Coinsurance" or "Co-insurance".** That portion of Covered Expenses in excess of any applicable Co-payment that is to be paid by the Participant.

1.16 **"Co-payment" or "Co-pay".** A dollar amount determined under Section 4.03, hereinbelow, that must be paid at the time Covered Expenses are incurred by a Participant.

1.17 **Cosmetic** - A substance intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to the human body for cleansing, beautifying, promoting attractiveness, or altering the appearance thereof.

1.18 **"Cosmetic Procedure".** A procedure performed primarily for the improvement of a Participant's appearance rather than for the improvement or restoration of bodily function(s).

1.19 **"Covered Expense", "Covered Expenses".** Expenses incurred by a Participant for any Medically Necessary Prescription Drugs or Supplies that are not specifically excluded from coverage elsewhere in this Plan.

1.20 **"Dependent-Participant".** An Eligible Dependent who has met the requirements of Section 2.02, herein and (if applicable) for whom all required Plan contributions are paid.

1.21 **"Disability Separated" or "Disability Separation".** The voluntary or involuntary termination of an Employee from his Employer due to that Employee's inability to perform the essential functions of his position because of a disabling illness, or injury. Disability Separated or Disability Separation shall be determined by the Employee's Employer; however, for the purposes of a Participant obtaining Employer-paid coverage in the event of unpaid medical

leave, layoff or disability described under Section 2.09, herein, the Plan Administrator may, in accordance with the provisions of Section 2.09.3, herein, overrule an Employer's determination that an Employee has been Disability Separated.

1.22 **"Documentation".** Written information to be provided by an Employee upon the request of the Plan Administrator, the Appeals Committee or their authorized representatives, as may be deemed necessary by the Plan Administrator and/or the Appeals Committee, to ensure compliance with the provisions of the Plan. The type of written information that may be required by the Plan Administrator and/or the Appeals Committee will depend on the situation and/or provision of the Plan in question; however, with respect to the following specific situations, the required written information may include, **but is not limited to**, the following:

(A) **Evidence an individual is a Spouse:** Photocopy of marriage certificate identifying both the Employee and his Spouse; and/or, photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ) that identifies the Spouse to the sole satisfaction of the Plan Administrator. (The submitter may redact the income totals if they choose.)

(B) **Evidence an individual is an Employee's dependent Child:**

(1) **Employee's Biological or Adopted Child:** Photocopy of a birth certificate identifying the Employee as a birth parent; or, photocopy of the court order or decree finalizing the adoption of the Child by the Employee; or photocopy of the page(s) of the Employee's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's dependent Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator (the submitter may redact the income totals if they so choose); or, any combination of the above listed information; or any additional documentation requested by the Plan Administrator or voluntarily provided by the Employee that adequately evidences dependent child eligibility.

(2) **Employee's step-child:** A photocopy of a birth certificate, court order or decree identifying the relationship of the Employee or his Spouse, to the child; or photocopy of the page(s) of the Employee's or Spouse's most recently filed Federal Tax Return (Form 1040, 1040-A or 1040-EZ that identifies that individual as the Employee's or the Spouse's Child (according to IRS rules and regulations) to the sole satisfaction of the Plan Administrator (the submitter may redact the income totals if they so choose); or,

any combination of the above listed information; or any additional documentation requested by the Plan Administrator or voluntarily provided by the Employee that adequately evidences a child's eligibility for Plan participation.

(3) **Child for Whom an Employee is the guardian:** Copy of court order or decree that establishes the Employee's guardianship over the child.

1.23 "**Effective Date".** This Plan is effective March 1, 2011.

1.24 **"Eligible Dependent".** An Eligible Employee's or Employee-Participant's:

(A) Spouse; and/or

(B) Child; and/or

(C) child who is determined by the Plan Administrator (in its sole discretion) to be an 'alternate recipient' entitled to Plan coverage pursuant to a Qualified Medical Child Support Order'.

The Plan Administrator reserves the right to require the Eligible Employee or Employee-Participant to submit Documentation satisfactory to the Plan Administrator, as it deems necessary, as to an Eligible Dependent's dependency status. This evidence of dependency status includes, but is not expressly limited to, whether a child can be considered an Eligible Dependent.

A person who is covered under this Plan as an individual Participant shall not qualify as an Eligible Dependent. See also Section 2.08, hereinbelow.

1.25 **"Eligible Employee".** An Employee or former Employee, who is not an Intermittent Employee.

1.26 **"Employee".** An individual employed by the Plan Sponsor or an Adopting Employer.

1.27 **"Employee-Participant**". An Eligible Employee who has met the requirements for Plan participation under Section 2.01, herein.

1.28 **"Employer".** The Plan Sponsor and/or an Adopting Employer as the context may require.

1.29 **"Employer Identification Number" or "EIN".** The taxpayer identification number issued to the Plan Sponsor by the Internal Revenue Service. The Plan Sponsor's EIN is 34-6400806.

1.30 "**Enrollment Date".** The first day of a Participant's coverage under this Plan or, if earlier, the beginning of any applicable waiting period.

1.31 **"ERISA".** The Employee Retirement Income Security Act of 1974 codified at 29 USC §1001 *et. seq*.

1.32 **"Experimental/Investigational".** Any Prescription Drug or Supply which is not recognized as an accepted medical practice or which did not have the requisite required United States government approval when received by the Participant.

1.33 **"Family".** An Employee-Participant and his Dependent-Participant(s).

1.34 **"Gross Annual Household Income".** The amount reported as 'total income' on the Employee-Participant's most recently filed Internal Revenue Service Form 1040 or 1040-A or the amount reported as 'adjusted gross income' on the Employee-Participant's most recently filed Form 1040-EZ, as applicable.

1.35 **"Health Insurance Portability and Accountability Act of 1996" or "HIPAA".** The law codified at 42 USC §1320-d *et.seq.*

1.36 **"Intermittent Employee".**

(A) An Employee whose full-time or part-time employment with the Employer is on a temporary or emergency basis that will not exceed ninety (90) consecutive calendar days; and /or

(B) an Employee whose employment with the Employer will not exceed fifteen hundred (1500) hours in any calendar year; and/or

(C) a “seasonal appointment”.

1.36.1 **“Seasonal appointment”.** For purposes of Section 1.36, an Employee who works a certain regular season or period of each calendar year performing some work or activity limited to that season or period of the year notwithstanding the requirements of Section 1.36(A).

1.37 **“Legal Separation”**. Separation (as defined under Section 1.61, herein) pursuant to a decree or order issued by a court of competent jurisdiction.

1.38 "**Lucas County Prescription Drug Use Review Program" or "DUR Program".** A program designed to utilize pharmacists and other healthcare professionals to help improve/maintain the health of Participants by performing a complete review of medications, providing education on common disease states related to the Participant's medications, monitoring blood pressure, glucose, cholesterol and HgbA1c as needed, and enhancing communication between pharmacist, Physician and Participant, as further explained under Section 3.03, herein.

1.39 **“Medically Necessary”.** A Prescription Drug or Supply which is necessary and appropriate for the diagnosis or active treatment of an illness or injury, as determined by the Plan Administrator, based on generally accepted current medical practice.

A Prescription Drug or Supply will NOT be considered Medically Necessary if it:

(A) is provided only as a convenience to the Participant or provider;

(B) is not appropriate treatment for the Participant’s diagnosis or symptoms;

(C) exceeds (in scope, duration, or intensity) that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;

(D) is part of a plan of treatment that is considered to be Experimental/Investigational or for research purposes in the diagnosis or treatment of an Illness or Injury;

(E) involves the use of a drug or substance not formally approved by the United States Food and Drug Administration; provided, however, that even if such approval is not required, the fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary; or

(F) involves the use of a drug or substance not normally utilized under generally accepted current medical practice, as determined in the sole discretion of the Plan Administrator.

1.40 "**Medicare".** The health insurance for the aged program established under Public Law 89-97 as subsequently amended from time to time.

1.41 **"Newborn".** The status of an infant from the time of the infant's birth until the earlier of :

(A) the infant's initial Hospital discharge; or

(B) the time at which the infant becomes seven (7) days old.

1.42 **Non-Participating Pharmacy".** A duly licensed pharmacy that provides, within the scope of its authority, Prescription Drugs and/or Supplies that are covered under this Plan but which has not directly or indirectly entered into a contract with the Plan Administrator to provide those Prescription Drugs and/or Supplies at a contracted rate.

1.43 **"Open-Enrollment Period".** An annual period of time established by the Plan Administrator during which:

(A) an Eligible Employee who has initially met the Plan's eligibility requirements may enroll in the Plan along with any Eligible Dependents; and/or

(B) an Employee-Participant may change Plan coverage for himself and/or his Eligible Dependents; and/or

(C) an Employee-Participant may add or drop Eligible Dependents from Plan coverage.

1.44 "Other Coverage". Any and all plans, insurance or other scheme that may pay, in whole or in part, for **medical care and Prescription Drugs and/or** Supplies provided to a Participant OTHER THAN plans sponsored by the Plan Sponsor.

1.45 **"Out-of-Pocket Maximum".** The Plan Year limit on **t**he total payments made for Covered Expenses under this Plan (e.g. Co-payments and Coinsurance) that a

Participant is responsible to pay as described in Section 4.03, "Schedule of Benefits", herein. When payments reach the Out-of-Pocket Maximum, benefits will increase to pay for 100% of a Participant's Participating Pharmacy Covered Expenses for the remainder of the Plan Year or benefit period in which the Out-of-Pocket Maximum is reached. Payments for:

(A) non-Covered Expenses; and

(B) expenses incurred through Non-Participating Pharmacies,

do not apply to the Out-of-Pocket Maximum.

1.46 **"Over-the-Counter Medication(s)" or "OTC".** A drug or Supply that is sold without the requirement of a prescription from a healthcare professional.

1.47 **"Participant".** An Employee-Participant and/or a Dependent-Participant, as the context may require.

1.48 **"Participating Pharmacy".** A duly licensed Pharmacy that provides, within the scope of its authority, Prescription Drugs and/or Supplies that are covered under this Plan and which has directly or indirectly entered into a contract with the Plan Administrator to provide those Prescription Drugs and/or Supplies to Participants at a contracted rate.

1.49 **"Pay".** The remuneration an Employee receives from an Employer.

1.50 **"Pharmacy".** A duly-licensed facility where Prescription Drugs are dispensed by a pharmacist pursuant to applicable federal and state laws.

1.51 **"Physician".** A duly licensed medical doctor, dentist or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist, certified consulting Psychologist or limited licensed Psychologist, who, within the scope of their licenses, are permitted to prescribe Prescription Drugs and/or Supplies.

1.52 "**Plan".** The Lucas County Prescription Drug Benefit Plan, effective March 1, 2011.

1.53 **"Plan Administrator".** The Plan Sponsor, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator has engaged the services of the Claims Administrator to process claims and perform other Plan-related services and may engage or utilize the services of other persons or firms to assist in the administration of the Plan, as it may deem necessary.

1.54 **"Plan Number".** The Plan Number is LUCAS.

1.55 **"Plan Sponsor".** The Board of County Commissioners, Lucas County Ohio, One Government Center, Suite 800, Toledo, Ohio 43604-2259, (419)213-4500**.**

1.56 **"Plan Year".** The twelve (12) consecutive month period commencing March 1 and ending the immediately following February 28/29.

1.57 **"Prescription Drug".** Any medicinal substance which is required to bear the label: "Caution: Federal law prohibits dispensing without prescription" (including compounded medications which contain at least one Prescription Drug), injectable insulin and contraceptive medications.

1.58 **"Prior Authorization or "Prior Authorized".** The process whereby the Participant or the Participant's Physician has notified the Claims Administrator in advance of a prescription for a certain Prescription Drug or Drugs that require(s) Prior Authorization, and whereby the Claims Administrator has reviewed the pertinent medical data, concurred with the decision of the attending Physician, and has authorized the prescribed Prescription Drugs(s) as a Covered Expense.

1.59 **"Protected Health Information" or "PHI".** Any individually identifiable information that is created or received by a HIPAA covered entity and which relates to the past, present or future physical or mental health or condition of an individual, the providing of health care to an individual or the past, present or future payment for the provision of health care to an individual. PHI can be oral or recorded in any form or medium.

1.60 **"Qualified Medical Child Support Order".** A court order, as defined and provided under ERISA Section 609, that directs the Plan to provide, or continue providing benefits under the Plan for the Child of a Participant who is the noncustodial parent of the Child, and which has been deemed 'qualified' by the Plan Administrator. In making its determination as to whether a medical support order is 'qualified' the Plan Administrator may (if deemed necessary in its sole

discretion) seek clarification and/or modification of the order up to and including the right to seek a hearing before the court that issued the order.

1.61 **"Separation" or "Separated"**. A determination made by the Plan Administrator in its sole discretion that the Employee-Participant and his Spouse have ceased cohabitation.

1.62 **"Spouse".**

(A) Except as otherwise provided under Sections 1.62.1 and 1.62.2, herein, an individual who:

(1) is legally married to an Employee-Participant or Eligible Employee; and

(2) is a resident of the United States; and

(3) legally resides in the United States.

For purposes of this paragraph (A), an individual is treated as a Spouse only if he or she is recognized as a lawful spouse under the laws of the state in which the Participant resides.

(B) A Participant may have only one (1) Spouse at a time.

1.62.1 **Special Rules Regarding Spouses in Common Law Marriages.**

(A) An individual seeking the status of Spouse through a claim of a common law marriage with an Employee in the state of Ohio on and after October 10, 1991, shall not qualify as a Spouse for purposes of this Plan.

(B) An individual who has entered into a common law marriage in the state of Ohio with an Employee prior to October 10,1991, or who has at any time entered into a common law marriage in any other jurisdiction that allows common law marriages, shall qualify as a Spouse; provided

(1) Documentation of the common law marriage is submitted to the Plan Administrator; and

(2) such Documentation is deemed by the Plan Administrator (in its sole discretion) as

satisfactorily substantiating the existence of the common-law marriage; and

(3) the common law marriage is recognized as valid by the state of Ohio.

1.62.2 **Special Rule Regarding Domestic Partners.** A same-sex, domestic partner of an Employee, who is not otherwise an Eligible Employee, shall be deemed to be the Employee's Spouse provided the Employee and his domestic partner meet the requirements for domestic partnership as described under Lucas County Board of Commissioners Resolution 09-1266.

1.63 **"Supplies", "Supply".** Non-durable disposable health care materials ordered or prescribed by a Physician, which are primarily and customarily used to serve a medical purpose and includes ostomy supplies, catheters, oxygen, and diabetic supplies. They cannot be used by an individual in the absence of illness or injury or repeatedly by different individuals.

1.64 **"Timely Application".** An application for initial participation or continued participation in the Plan:

(A) made by an Eligible Employee or (in the case of mandatory re-enrollment) Employee-Participant on his own behalf and/or on behalf of his Eligible Dependent(s) or (in the case of mandatory re-enrollment) Dependent-Participants; and

(B) that is received and approved by the Plan Administrator:

(1) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) met the Plan's participation requirements under Sections 2.01 and/or 2.02, herein; or,

(2) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee and/or his Eligible Dependent(s) lost 'primary' Other Coverage previously selected in lieu of Plan coverage, as described in Section 2.03(A) and (B), herein; or

(3) within thirty-one (31) days (plus any extensions granted by the Plan Administrator) of the date on which the Eligible Employee acquired a new Eligible Dependent, or

(4) on or before such other date established by the Plan or Plan Administrator (plus any extensions of that date granted by the Plan Administrator) as being the deadline for submitting all materials relating to:

(a) an enrollment in the Plan for any reason not listed hereinabove in this Section 1.64; or,

(b) a mandatory re-enrollment required by the Plan Administrator.

(C) In the event the Plan Administrator receives an incomplete application (as determined in its sole discretion) during the thirty-one (31) day period described in Section 1.64(B)(1), (2) and (3) (plus any extensions granted by the Plan Administrator) or before the deadline date (plus any extensions granted by the Plan Administrator) described in Section 1.64(B)(4), the Eligible Employee or Employee-Participant (as applicable) submitting the application shall be contacted by the Plan Administrator (or its designee) and shall be informed of the corrections that must be made or the missing information that must be supplied in order for the application to be deemed complete along with a deadline date by which the properly completed application must be returned to the Plan Administrator who, upon receipt, will again review the application for completeness and approval.

(D) Failure of the Eligible Employee or Employee-Participant (as applicable) to return an application, completed to the sole satisfaction of the Plan Administrator, by the applicable date (plus any extensions) established by the Plan or the Plan Administrator, shall result in the Eligible Employee or Employee-Participant (as applicable) not being deemed to have made Timely Application.

1.65 **"Total Disability" or "Totally Disabled".** The physical state of a Participant or Eligible Dependent resulting from an Illness or Injury which wholly prevents

(A) the Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and/or

(B) an Eligible Dependent, from performing the normal day-to-day living activities of a person of like age and sex in good health; provided, however, the Eligible Dependent is not institutionalized and resides with the Participant at the Participant's residence,

as determined by the Plan Administrator in its sole discretion based on Documentation satisfactory to the Plan Administrator. Subsequent to an initial

determination of the Plan Administrator that a Participant or Eligible Dependent is Totally Disabled, the Plan Administrator shall have the right to reasonably request, at any time, updated Documentation relating to the Eligible Dependent's or Participant's condition for the purpose of determining whether the Participant or Eligible Dependent continues to be Totally Disabled. If, after reviewing the updated Documentation the Plan Administrator, in its sole opinion, determines that the Eligible Dependent or Participant is no longer Totally Disabled, the Eligible Dependent or Participant shall lose Total Disability status on the last day of the month following the date such determination made by the Plan Administrator.

This definition is separate and distinct from the definition of "Total Disability for Social Security Purposes" described under Section 6.01(G), hereinbelow.

ARTICLE 2.0

ELIGIBILITY AND PARTICIPATION

2.01 **Participation Requirements for Eligible Employees**.

An Eligible Employee who has been Actively at Work more than twenty (20) hours per week over a period of four (4) consecutive weeks and who has made Timely Application, shall become an Employee-Participant at 12:01 a.m., local time on the thirty-first (31st) calendar day following that Eligible Employee's meeting the foregoing 'Actively at Work' requirement.

2.01.1 **Timely Application Not Made: Eligible Employee or Employee-Participant.**

In the event an Eligible Employee or (in the case of a mandatory re-enrollment required by the Plan Administrator) an Employee-Participant:

(A) meets the 'Actively at Work' requirement described in Section 2.01; and

(B) does not make Timely Application; or

(C) does not waive participation in the Plan,

the Plan Administrator may, in its sole discretion, enroll that Eligible Employee or Employee-Participant in the Plan.

Following such enrollment by the Plan Administrator, the Employee-Participant shall be permitted to elect a different coverage option during the Open-Enrollment Period coincident with or immediately following his enrollment by the Plan Administrator.

2.02 **Participation Requirements for Eligible Dependents.**

(A) An Eligible Dependent who is a Newborn shall become a Dependent-Participant at the moment of birth, following Timely Application by the Employee-Participant.

(B) An Eligible Dependent who is a newly-adopted Child shall become a Dependent-Participant from the moment the Child's adoption is finalized by the court, following Timely Application by the Employee-Participant.

(C) An Eligible Dependent who is a Child for whom the Employee-Participant is the court-ordered guardian or court-ordered custodian shall become a Dependent-Participant at the time the guardianship or custody arrangement becomes effective, following Timely Application by the Employee-Participant.

(D) An Eligible Dependent who is an 'alternate recipient' under a Qualified Medical Child Support Order shall become a Dependent-Participant at the time specified in the order.

(E) An Eligible Dependent who is a Spouse shall become a Dependent-Participant from the date of marriage or satisfaction of the domestic partnership requirements described in Section 1.62.2, hereof, following Timely Application by the Eligible Employee or Employee-Participant provided, however, that as a further condition of Plan participation, the Spouse must at all times reside in the Eligible Employee's or Employee-Participant's household.

2.02.1 **Waiver of Participation or Failure of Timely Application For Eligible Dependent or Dependent-Participant.**

(A) In the event the Employee-Participant does not make Timely Application for his Eligible Dependent upon initially meeting the Plan's participation requirements, the Employee-Participant shall not be permitted to enroll such Eligible Dependent in the Plan until the immediately following Open-Enrollment Period.

(B) In the event of a mandatory re-enrollment required by the Plan Administrator the Employee-Participant fails to make Timely Application for the re-enrollment of his Dependent-Participant, the Dependent-Participant's participation in the Plan shall be terminated as of the March 1 immediately following the mandatory re-enrollment period and the Employee-Participant shall be prohibited from re-enrolling the Dependent–Participant until the immediately following Open-Enrollment Period.

2.02.2 **Participation Requirements for Eligible Dependents Losing Coverage Under Other Coverage; Eligible Dependents Acquired After Initial or Open Enrollment.**

An Employee-Participant:

(A) whose Eligible Dependent (other than a Spouse) lost 'primary' Other Coverage or,

(B) who added a new Eligible Dependent through marriage, birth, adoption or placement for adoption,

shall cause the Eligible Dependent to become a Dependent-Participant as of the date of the Eligible Dependent's loss of such Other Coverage or the date the Eligible Dependent is added to the Employee-Participant's Family, after making Timely Application for that Eligible Dependent. Failure of the Employee-Participant to make Timely Application on behalf of the Eligible Dependent described in Section 2.02(A) or (B), above, will render that Eligible Dependent ineligible for Plan participation until the next Open-Enrollment Period.

2.02.3 **Special Rules Applicable to Spouses.**

(A) **Plan Coverage for Spouse-General Rule.**

(1) **Contribution for 'Primary' Coverage Prior to March 1, 2012.**

Prior to March 1, 2012, an Employee-Participant whose Spouse is a Dependent-Participant under the Plan and whose Gross Annual Household Income is less than seventy-five thousand dollars ($75,000) shall be required to make a monthly contribution of seventy-five dollars ($75.00) to the Plan in order to maintain 'primary' Plan coverage for his Spouse. For an Employee-Participant whose Gross Annual Household Income is seventy-five thousand dollars ($75,000) or more, the required monthly Plan contribution for 'primary' Plan coverage for the Spouse is one hundred dollars ($100.00).

(2) **Contribution for 'Primary' Coverage On and After March 1, 2012**

On and after March 1, 2012, an Employee-Participant whose Spouse is a Dependent-Participant under the Plan and whose Gross Annual Household Income is less than seventy-five thousand dollars ($75,000) shall be required to make a monthly contribution of one hundred dollars ($100.00) to the Plan in order to maintain 'primary' Plan coverage for his Spouse. For an Employee-Participant whose Gross Annual Household Income is seventy-five thousand dollars ($75,000) or more, the required monthly Plan contribution for spousal coverage is one hundred fifty dollars ($150.00).

(3) **No Contributions for 'Secondary' Coverage**

There is no contribution or premium required for a Spouse who receives only 'secondary' coverage under the Plan.

(4) **Contributions Paid Through Section 125 Plan**

The contributions required under Section 2.02.3 shall be paid pursuant to the provisions of Section 2.06.1, herein.

(B) **Spouse Eligible for Other Coverage Through Spouse's Employer; Secondary Coverage of Spouse Under the Plan.**

Effective January 1, 2003, and except as provided in Section 2.02.3(B)(1), below, if the Spouse of an Employee-Participant is eligible for Other Coverage, that Spouse MUST enroll in 'single' (i.e. one-person) 'primary' coverage under that Other Coverage REGARDLESS of any premium or contribution that may be required for participation. An Employee-Participant, whose Spouse so enrolls in the Other Coverage shall be permitted to make Timely Application for 'secondary' Plan coverage of the Spouse.

(1) **Exemptions for 'excessive premium' and 'hardship'.**

Notwithstanding the foregoing provisions of this Section 2.02.3(B), a Spouse described therein shall NOT be required to participate in his employer's Other Coverage and the Employee-Participant may make Timely Application for 'primary' coverage for the Spouse under the Plan provided the Employee-Participant provides Documentation to the sole satisfaction of the Plan Administrator that the Spouse would be required to pay an 'excessive premium' for participation or coverage in the Other Coverage. An 'excessive premium' is the amount the Spouse would have to pay for participation or coverage in the Other Coverage that equals or exceeds 40% of that employer's premium for its lowest-cost 'single' 'primary' coverage.

Furthermore, an exemption to the general rule described in Section 2.02.3(B) shall be granted in cases where the Employee-Participant provides Documentation, to the sole satisfaction of the Plan Administrator, that the Gross Annual Household Income of the Employee-Participant and

Spouse amounts to seventy-five thousand dollars ($75,000) or less.

(C) **Spouse Not Eligible for Other Coverage; Spouse's Employer Does Not Maintain Health Insurance Program or Plan.**

If the employer of a Spouse either:

(1) does not sponsor or maintain Other Coverage; or

(2) sponsors or maintains Other Coverage but the Spouse is ineligible to join or participate in that Other Coverage, then upon making Timely Application for the Spouse's Plan coverage, the Employee-Participant is required to provide Documentation, to the sole satisfaction of the Plan Administrator, printed on the official letterhead of the Spouse's employer and signed by the appropriate management level executive, stating that Spouse is not eligible for the employer's Other Coverage or that the employer does not sponsor or maintain Other Coverage.

(D) **Spousal Retiree Coverage.**

(1) If the retired Spouse of an Employee-Participant is eligible for retiree Prescription Drug insurance benefits (other than Medicare) through a former employer of the Spouse, that Spouse MUST enroll in single, 'primary' coverage in any retiree Prescription Drug insurance plan or program sponsored by the Spouse's former employer regardless of any premium required for participation. Retired Spouses of Employee-Participants who are eligible for no other Prescription Drug coverage other than Medicare may enroll for 'primary' coverage under the Plan subject to the Employee-Participant's payment of any premium or other payroll deduction required under the Plan for such 'primary' coverage for the Spouse. Retired Spouses of Employee-Participants who elect Medicare for their 'primary' Prescription Drug insurance coverage are not eligible to enroll in the Plan.

(2) For purposes of 'spousal retiree coverage' under this Section 2.02.3(D), the exemptions for 'excessive premium' and 'hardship' described under Section 2.02.3(B)(1) hereinabove, shall not apply.

(3) In the event the retired Spouse of an Employee-Participant loses retiree Prescription Drug insurance coverage for any reason the Employee-Participant shall be required to report such loss of coverage to the Plan Administrator no later than thirty-one (31) days following such loss of coverage. Failure of the Employee-Participant to report such loss of coverage will result in the retired Spouse being ineligible to enroll for 'primary' coverage under this Plan or in any other health insurance plan or program sponsored by the Plan Sponsor until the next Open Enrollment Period.

(E) **Failure to Properly Enroll Spouse; Dependent-Participant Spouse Separated; Recovery of Amounts Expended for Separated Spouse.**

(1) An Employee-Participant who fails or failed to properly enroll his Spouse in the Plan shall be responsible for any and all claims and costs incurred by and for that Spouse under the Plan. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during the time the Spouse was not properly enrolled in the Plan.

(2) A Spouse who incurred claims or costs under the Plan as a Dependent-Participant, but who was Separated from the Employee-Participant at the time such claims or costs were incurred, shall be responsible for any and all such claims and costs. The Plan Administrator shall exercise all rights of recovery for any and all amounts expended by the Plan during a period of time when such Spouse was Separated from the Employee-Participant.

2.03 **Waiver of Coverage and Subsequent Loss of Other Coverage.**

An Eligible Employee:

(A) who waived, in writing, Plan participation for himself and/or his Eligible Dependent(s) upon attaining initial eligibility for participation in the Plan; and

(B) whose written waiver stated Plan participation was declined because the Eligible Employee and/or Eligible Dependent had obtained Other Coverage on a ‘primary’ basis; and

(C) who subsequently loses the Other Coverage for himself and/or his Eligible Dependent(s);

shall, following Timely Application, become a Participant, along with his Eligible Dependent(s) at 12:01 a.m. (local time) on the day after the Other Coverage was lost, PROVIDED, however, that the Eligible Employee and/or any Eligible Dependent:

(D) was (were) under the Other Coverage's Consolidated Omnibus Budget Reconciliation Act continuation coverage and such continuation coverage was exhausted; or

(E) was (were) not under such Consolidated Omnibus Budget Reconciliation Act continuation coverage and the Other Coverage was terminated as a result of:

(1) loss of eligibility; or

(2) employer contributions toward such Other Coverage were terminated.

Notwithstanding anything in this Section 2.03 to the contrary, an Eligible Employee and/or Eligible Dependent who lost the Other Coverage due to nonpayment of premium(s) or for 'cause' (e.g., filing fraudulent claims) shall not be permitted to enroll in the Plan pursuant to this Section 2.03 and shall, instead, be required to satisfy the requirements of Section 2.01 and (if applicable) Section 2.02, hereof.

2.04. **Maintenance of Participant Status; Loss of Plan Coverage.**

(A) **Maintenance of Participant Status.**

An Employee-Participant hired prior to March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) for any month or any portion of the month in which the Employee-Participant is in Active Pay Status or Active Work Status. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage, for the Employee-Participant and any Dependent-Participant, at the end of the last day of the month in which the requirement is not satisfied unless otherwise provided herein.

An Employee-Participant hired on or after March 1, 2001 shall maintain coverage under this Plan for himself and his Dependent-Participant(s) provided the Employee-Participant is in Active Pay Status or Active Work

Status for a minimum of 80 hours during a calendar month. Failure of the Employee-Participant to meet the immediately foregoing 'Active Pay Status' or 'Active Work Status' requirement shall result in the loss of Plan coverage for the Employee-Participant and any Dependent-Participant and/or Spouse at the end of the last day of the month in which the requirement is not satisfied, unless otherwise provided herein.

(B) **Spouse's Loss of Coverage Due to Divorce, Annulment, Dissolution, Separation, Legal Separation, Termination of Domestic Partnership; Last Day of Plan Coverage; Employee-Participant Duty to Notify Plan Administrator.**

Notwithstanding anything in this Section 2.04 to the contrary, Plan coverage (except for COBRA coverage, as applicable) for a Spouse who is a Dependent-Participant shall cease on the day the Spouse's divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation from, or termination of domestic partnership with, the Eligible Employee or Employee-Participant becomes 'final'. For purposes of this Section 2.04, a:

(1) Separation is 'final' on the date the Plan Administrator, in its sole discretion, has determined that the Employee-Participant no longer cohabitate.

(2) Divorce, annulment of marriage, dissolution of marriage or Legal Separation is 'final' on the date the court's order or decree relating to the divorce, annulment of marriage, dissolution of marriage or Legal Separation is journalized by the court.

(3) Termination of a domestic partnership is 'final' on the date a 'Notice of Termination of Domestic Partnership' is filed with the City of Toledo, Ohio in accordance with Toledo Municipal Code Section 114.05 or the Plan Administrator receives written notice of the termination of the domestic partnership.

The Employee-Participant who is a party to the Spouse's divorce, annulment of marriage, dissolution of marriage, Separation, Legal Separation or termination of domestic partnership is required to immediately notify the Plan Administrator of the occurrence of any of the events described in this paragraph (B).

(C) **Loss of Coverage Due to Employee-Participant's Termination of Employment, Retirement, Death, Military Service, Plan Termination and Last Day of Coverage.**

(1) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant at midnight of the last day of the month in which the Employee-Participant's employment with an Employer is terminated.

(2) Except as otherwise provided, an Employee-Participant who retires from an Employer shall lose Plan coverage for himself and any Dependent-Participant on the date that Employee-Participant becomes eligible for benefits under the Ohio Public Employees Retirement System.

(3) Except as otherwise provided, an Employee-Participant shall lose Plan coverage for himself on the date of his death. Plan coverage for Dependent-Participants of the deceased Employee-Participant shall continue through the last day of the month in which the Employee-Participant died.

(4) Except as otherwise provided under Section 2.11 hereinbelow, an Employee-Participant shall lose Plan coverage for himself and any Dependent-Participant on the date the Employee-Participant enters active United States military service.

(5) Coverage for all Employee-Participants and their Dependent-Participants shall cease on the date the Plan is terminated.

(D) **Loss of Coverage Due to Strike.**

Pursuant to Ohio Revised Code Section 4117.15(C), no Employee-Participant (along with any Dependent-Participant) shall be entitled to Lucas County-paid employee benefits (including Employer-paid coverage under this Plan) for the period during which the Employee-Participant is engaged in any strike against his Employer.

If eligible for COBRA coverage, a striking Employee-Participant will be offered COBRA coverage in accordance with Article 6.0, herein. In the event the striking Employee-Participant returns to Active Work Status after having paid a COBRA premium while on strike, that Employee-Participant will be reimbursed a pro-rata portion of the paid COBRA premium for the portion of the month the Employee-Participant was not on strike PROVIDED the Employee-Participant meets the requirements of Section 2.04(A).

(E) Special Rules Regarding Employees and Worker's Compensation

(1) **Special Rule for Employee-Participants Placed on Worker's Compensation before March 1, 2011.**

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer commencing before March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participant(s) for a period of up to two (2) years following the commencement of such leave of absence.

(2) **Special Rule for Employee-Participants Placed on Worker's Compensation On and After March 1, 2011**

An Employee-Participant who is no longer Actively at Work because he has been placed on a worker's compensation leave of absence from an Employer on or after March 1, 2011 shall retain Plan coverage for himself and any Dependent-Participants for a period of up to twelve (12) months following the commencement of such leave of absence.

(3) **Duration of Coverage for Employee-Participant on Worker's Compensation.**

The two (2) year period [twelve (12) month period on and after March 1, 2011] of Employer-paid Plan coverage described in Section 2.04(C)(1) and (2) is a "lifetime" limit that applies per Employee-Participant without regard to:

(a) the number of Employers he is or may have been employed by; or

(b) the number of times he may have been on a worker's compensation leave of absence from an Employer (subject to the limitations of paragraph (4), below).

That is, prior to March 1, 2011, a Participant is "credited" with two (2) years of Employer-paid Plan coverage that may be received during workers' compensation leaves of absence from an Employer [on and after March 1, 2011, the two (2) year period is reduced to become twelve (12) months of Employer-paid Plan coverage]. The two (2) year or twelve (12) month period (as applicable) is reduced by number of days during which Employer-paid Plan coverage was provided to the Employee-Participant during any and all workers' compensation leaves of absence from an Employer .

(4) **Workers' Compensation Leave of Absence and Employer-Paid Coverage Commencing Before March 1, 2011 and Ending After March 1, 2011; Employer-paid Coverage Offset.**

An Employee-Participant whose workers' compensation leave of absence from an Employer and Employer-paid Plan coverage begins prior to March 1, 2011 and continues beyond that date shall be eligible for Employer-paid Plan coverage during such leave of absence up to the two (2) year limit described under Section 2.04(C)(1), above, notwithstanding the reduction in the duration of the Employer-paid coverage period effective March 1, 2011.

An Employee-Participant:

(a) whose worker's compensation leave of absence from an Employer and Employer-paid Plan coverage commenced prior to March 1, 2011 and ended after March 1, 2011 ("original leave of absence"); and

(b) who, subsequent to the end of the "original leave of absence" described in the immediately preceding paragraph (a), is placed on a new worker's compensation leave of absence from an Employer,

shall be eligible for twelve (12) months of Employer-paid Plan coverage, as described under Section 2.04(C)(2); provided, however, that such twelve (12) month period of coverage shall be reduced by the number of days Employer-paid Plan coverage was provided to the Employee-Participant under the "original leave of absence" for the period of time on and after March 1, 2011.

(F) **Loss of Coverage by a Child**

(1) Plan coverage for a Dependent-Participant who is a Child defined under Section 1.10(A), (B) or (C) will terminate the end of the month in which that Dependent-Participant reaches age 26; however, such termination of coverage may be extended to the end of the month in which that Dependent-Participant reaches age 28 under certain circumstances, provided Timely Application is made to the Plan Administrator by the Employee and any Documentation required by the Plan Administrator is timely submitted.

(a) Notwithstanding anything in the immediately foregoing paragraph (1), a Dependent-Participant who is a Child defined under Section 1.10(A), (B) or (C) who has been determined to be Totally Disabled may have coverage

extended beyond age 26 or age 28 (whichever is applicable) upon Timely Application and timely submission of any Documentation required by the Plan Administrator. Such an extension shall continue until the earlier of the date of the Dependent-Participant's death, the date the Dependent-Participant no longer resides at the Employee-Participant's residence or the last day of the month in which the Plan Administrator has determined that the Dependent-Participant is no longer Totally Disabled.

(2) Plan coverage for a Dependent-Participant who is a Child defined under Section 1.10(D), hereinabove, will terminate at the end of the month in which such Dependent-Participant reaches the State of Ohio's age of majority, unless otherwise provided elsewhere in this Plan document.

2.05 **Loss of Participant Status and Subsequent Eligibility.**

An Employee-Participant who:

(A) loses Employee-Participant status;

(B) has not elected COBRA coverage; and

(C) has had thirty (30) days or less elapse before resuming Active Work Status

shall again become an Employee-Participant immediately upon resuming Active Work Status.

An Employee-Participant who has met the conditions of Sections 2.05(A) and (B), but who has had MORE THAN thirty (30) days elapse before resuming Active Work Status shall be treated as a new Eligible Employee and shall be required to meet the requirements of Section 2.01, hereof.

2.05.1 **Special Rule for Employees Receiving OPERS Disability Retirement Benefits**

In the event an Employee-Participant:

(A) becomes Disability Separated; and

(B) loses Employee-Participant status; and

(C) qualifies for disability retirement health benefits from the Ohio Public Employees' Retirement System ("OPERS"); and

(D) has his OPERS disability retirement health benefits terminated by OPERS on or before the fifth (5th) anniversary of the date his Disability Separation became effective, and

(E) resumes Actively at Work status,

then, upon resuming Actively at Work Status, that former Employee-Participant shall be treated as an Eligible Employee who shall again become an Employee-Participant on the day after his OPERS disability retirement health benefits ended upon making Timely Application provided:

(F) (in the case of an Eligible Employee whose initial date of hire was before March 1, 2001) the Eligible Employee was Actively at Work for any portion of calendar month in which he resumed employment; or

(G) (in the case of an Eligible Employee whose initial date of hire was on or after March 1, 2001) the Eligible Employee was Actively at Work for an average of twenty (20) hours per week or eighty (80) hours total during the thirty-one (31) consecutive day period commencing with the day he resumes Actively at Work status.

2.06 **Plan Contributions and Participation.**

The Plan Administrator may require a contribution from or on behalf of a Participant in order to maintain participation in the Plan. An Eligible Employee will be advised of any contributions required for him and/or any Eligible Dependent at the time application for Plan participation is made. Participants in the Plan will be notified by the Plan Administrator prior to an increase in any required contribution amount.

2.06.1 **Contributions/Premiums Paid Through Section 125 Plan.**

Any and all contributions or premiums required for Plan participation shall be paid through payroll deduction made to the Lucas County Flexible Benefits Plan, as amended and restated effective March 1, 2008, unless the Plan Administrator is notified in writing by the Eligible Employee or Employee-Participant that an alternate method of payment is requested and the Plan Administrator agrees, in writing, to the alternate method of payment.

2.07 **Failure of Spouse or Eligible Dependent to Enroll in 'Primary' Coverage in Employer's Plan; Incentives to Decline Coverage.**

A Spouse who:

(A) is employed by an employer other than an Employer, and

(B) fails to enroll for 'primary' coverage in their employer's Other Coverage, or

(C) declines or drops such coverage because he elected a different benefit, or accepted a cash payment, in lieu of such coverage (regardless of any premium or contribution required by the employer for participation)

shall not be eligible to participate in the Plan.

Under no circumstances shall the Plan pay any bills for any Prescription Drug expenses incurred by a Spouse, Eligible Dependent or Dependent-Participant who directly or indirectly accepted cash or other incentives to not enroll in another employer's medical insurance plan or program provided that employer's medical insurance plan or program contained Prescription Drug coverage or maintained a Prescription Drug component.

2.08 **Employee and Spouse Both Employed by an Employer.**

An Employee and his Spouse, both of whom are Eligible Employees, will be required to choose between the following Plan coverage options:

(A) separate 'single' coverage for each of them; or

(B) sole 'Family' coverage covering both of them.

In the case where an Employee and Spouse, BOTH of whom are employed by an Employer; and

(C) EITHER of whom maintained 'family' coverage under the Plan and the holder of such 'family' coverage had their employment with their Employer terminated (whether voluntarily or involuntarily); or

(D) BOTH of whom carried "single" coverage under the Plan and one of them has their employment with their Employer terminated (whether voluntarily or involuntarily

then the 'employed individual' may request a change to 'family' coverage, effective as of the date the 'terminated individual' would otherwise have lost

coverage. The 'terminated individual' shall become, and shall be treated as, a Spouse seeking coverage under the Plan as described under Section 2.02.3, hereinabove. The 'employed individual' is solely responsible for making Timely Application for coverage of the 'terminated individual' within 31 days of the termination of employment (plus any extensions that may have been granted by the Plan Administrator).

Solely for purposes of this Section 2.08 'terminated individual' shall mean terminated and 'employed individual' shall mean the Employee or Spouse who continues employment with their Employer.

2.09 **Employer-Paid Coverage in the Event of Unpaid Medical Leave, Disability, Layoff.**

(A) An Employee-Participant who:

(1) has exhausted his/her paid sick leave and is awarded an unpaid Authorized Medical Leave of Absence; or

(2) has been laid off and did not, or does not, become eligible for any other group health insurance coverage by reason of new employment, retirement, disability retirement or social security retirement; or

(3) has become Disability Separated

is eligible for continued Employer-paid Plan coverage for himself and any Dependent-Participant for up to twelve (12) months following the otherwise-scheduled expiration of such coverage provided that Employee-Participant has been in Active Pay Status during the twelve (12) consecutive month period immediately preceding the effective date of the unpaid Authorized Medical Leave of Absence, layoff or Disability Separation.

2.09.1 **Twelve (12) Month Period of Coverage is Lifetime Limit.**

The twelve (12) month period of Employer-paid Plan coverage described in Section 2.09 is a "lifetime" limit that applies per Employee-Participant without regard to:

(A) the number of Employers he is or may have been employed by; or

(B) the number of times he may have been awarded an Authorized Medical Leave of Absence or Disability Separation, or was laid off.

That is, upon becoming a Participant, each Employee-Participant is "credited" with twelve (12) months of Employer-Paid Plan coverage that may be provided under Section 2.09. The twelve (12) month period is reduced by each period of time Plan coverage was provided to the Employee-Participant pursuant to Section 2.09.

Notwithstanding anything in the immediately foregoing paragraph to the contrary, nothing in this Section 2.09.1 shall limit, or be interpreted as limiting, an Employee's right to continued benefits under the Family Medical Leave Act. Additional coverage beyond the twelve (12) month period of Employer-paid Plan coverage shall be provided if and as required under the Family Medical Leave Act.

2.09.1.1 **Maximum Amount of Employer-Paid Plan Coverage**

(A) The twelve (12) month period of Employer-paid Plan coverage described in Section 2.09 shall be reduced by periods of Employer-paid coverage (not to exceed a total of six (6) months) provided under the provision entitled "Extended Disability and Lay-Off" under the Lucas County Employee Health Benefit Plan (Revised March 1, 2007) as it existed prior to the Effective Date of this Plan (the "prior plan").

(B) In the event an Employee-Participant was receiving Employer-paid Plan coverage under the "Extended Disability and Lay-Off" provision of the "prior plan" and such coverage continued beyond the Effective Date, the Employee-Participant shall be entitled to a maximum of six (6) months of Employer-paid Plan coverage from the date such coverage began under the "prior plan" (i.e. the fact that the Employee-Participant's continuous period of disability or layoff began prior to the Effective Date of the Plan and continued after the Effective Date of the Plan would not entitle that Employee-Participant to a maximum additional six (6) months of Employer-paid Plan coverage). However, if:

(1) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff began prior to March 1, 2011; and

(2) the Employee-Participant's Authorized Leave of Absence, Disability Separation or layoff ended on or after March 1, 2011; and

(3) the Employee-Participant was Actively at Work after the end of his Authorized Leave of Absence, Disability Separation or layoff; and

(4) the Employee-Participant subsequently incurred a new Authorized Leave of Absence, Disability, Separation, or layoff

that Employee-Participant shall be entitled to twelve (12) months of Employer-paid Plan coverage LESS the amount of time he received Employer-paid Plan coverage for Authorized Leave of Absences, Disability Separations or layoffs that began and ended before March 1, 2011 and/or that began prior to March 1, 2011 and ended after March 1, 2011.

2.09.2 **COBRA Coverage After Exhaustion of Employer-Paid Coverage.**

An Employee-Participant who has exhausted the twelve (12) month period of Employer-paid coverage described in Section 2.09 shall be eligible for COBRA coverage as described under Article 6.0, herein.

2.09.3 **Plan Administrator's Disagreement With Award of Authorized Medical Leave of Absence and/or Disability Separation and Right to Require Independent Examination of Employee- Participant.**

The Plan Administrator shall have the right to challenge the award of an Authorized Medical Leave of Absence or Disability Separation for purposes of an Employee-Participant seeking the Employer-paid coverage described in Section 2.09. In challenging the award of an Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator shall have the right to require that the Employee-Participant be examined by an independent medical examiner of the Plan Administrator's choosing, at the expense of the Plan Administrator, for the purpose of determining whether, for Plan purposes and in the Plan Administrator's sole opinion, the Authorized Medical Leave of Absence or Disability Separation is warranted by the Employee-Participant's medical condition(s). Failure of the Employee-Participant to submit to the independent medical examination required by the Plan Administrator shall result in a denial of the additional Employer-paid coverage to the Employee-Participant and his Dependent-Participant.

Each Employee-Participant is deemed, through his participation in the Plan, to authorize the Plan Administrator to review the results of the independent medical examination. If, in the Plan Administrator's sole opinion, the results of the examination do not support the award of the Authorized Medical Leave of Absence or Disability Separation, the Plan Administrator may, in its sole discretion, deny the twelve (12) month Employer-paid coverage. The Plan Administrator's decision shall be final and binding.

2.10 **Family and Medical Leave Act ('FMLA').**

All provisions relating to Plan coverage and participation are intended to be in compliance, and shall comply, with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to an Employer, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provision that conflicts with the FMLA is superseded by the FMLA to the extent such provision conflicts with the FMLA. A Participant with questions concerning any FMLA rights and/or obligations should contact his Employer.

2.11 **Military Leaves of Absence**.

Employee-Participants and/or Dependent-Participants on approved military leaves will have Plan benefits provided in accordance with the Uniformed Services Employment and Re-employment Rights Act ("USERRA") and any policy or provisions enacted by the Plan Sponsor.

ARTICLE 3.0

PRIOR AUTHORIZATION, DRUG USE REVIEW PROGRAM AND NETWORK PROVIDERS

3.01 **Services Requiring Prior Authorization.**

In order for certain services to be covered under this Plan, the following Prescription Drugs and/or Supplies MUST be Prior Authorized by the Claims Administrator:

(A) All medications costing more than five hundred dollars ($500.00) per dose;

(B) Any other Prescription Drug or Supply deemed by the Plan Administrator, in its sole discretion, to require Prior Authorization.

The Claims Administrator must be notified in advance of the provision of the any of the foregoing Prescription Drugs and/or Supplies. Upon such notification, the Claims Administrator will obtain the data needed to review the plan of treatment recommended by the Participant's attending Physician. Following its review, the Claims Administrator will either:

(C) Agree with the Participant's attending Physician, in which case it will issue Prior Authorization of the Prescription Drug or Supply; or

(D) Disagree with the Participant's attending Physician because the indication of the Prescription Drug or Supply may not match pre-approved exception criteria, in which case the Prior Authorization will be denied. The denial will be supplied to the foregoing immediately in writing by facsimile.

Upon receipt of the Prior Authorization denial, the Participant is entitled to appeal the Claims Administrator's decision through the appeals process described under Section 9.02, herein.

3.01.1 **'Step Therapy'.**

The Claims Administrator reserves the right to utilize 'step therapy'.

Under 'step therapy' the Claims Administrator may, at any time and at its sole discretion, identify certain Prescription Drugs and/or Supplies that do not provide therapeutic outcomes relevant to their cost. In the event a Participant is using a Prescription Drug or Supply that has been so

identified, the Claims Administrator will notify the Participant utilizing said medication and/or Supply ("higher-cost medication or Supply"), of other lower-cost medications or Supplies that provide comparable therapeutic outcomes. The Participant shall be required to use the lower-cost medication or Supply for a sufficient period of time (as determined in the sole discretion of the Claims Administrator) that will permit the Participant and his Physician to determine whether the lower-cost medication or Supply is effective.

Failure of the Participant to try the lower-cost alternative as described in the immediately preceding paragraph, or failure/refusal of the Physician to prescribe the lower-cost alternative shall result in the Claims Administrator immediately rejecting any claims for the "higher-cost medication or Supply" submitted by the Participant to the Plan.

If the lower-cost medication or Supply has been determined to be ineffective by the Participant and his Physician, the Claims Administrator may, in its sole discretion, approve claims for the Participant's "higher cost medication or Supply" provided the Claims Administrator has received Documentation from the Participant's Physician demonstrating to the Claims Administrator's sole satisfaction that the lower-cost alternative is not effective.

Notwithstanding anything in this Section 3.01.1 to the contrary, in no event shall the Claims Administrator pay any claim submitted for a Prescription Drug or Supply excluded from coverage under this Plan

3.02 **Incapacity of Participant.**

In the event the Participant cannot obtain Prior Authorization due to incapacity (e.g. the Participant is unconscious) and no Close Relative, guardian of the Participant or other individual responsible for the care of the Participant is aware of the Prior Authorization process, any denial of Plan coverage for Prescription Drugs or Supplies will automatically be referred to the appeals process described in Section 9.02, herein, for disposition.

3.03 **Drug Use Review Program**

Participants may avail themselves of the Lucas County Prescription Drug Use Review Program. The DUR Program has been designed to utilize pharmacists and other healthcare professionals to help improve/maintain the health of Participants. The following is a description of the program:

(A) Eligibility.

All Participants are eligible to participate in the DUR Program.

(B) Services Provided by the DUR Program.

One-on-one visits with a pharmacist;

Education on common disease states related to the Participant's medications;

Complete review of medications and how they work to give the Participant an understanding of the role each medication plays in their related disease state including: how and when to take the medication(s), side effects, drug interactions, identifying cost-savings opportunities, and determining medication adherence and resolving issues related to missed doses;

Monitoring blood pressure, blood glucose, cholesterol and $HgbA_{1C}$ as needed;

Working with a pharmacist to identify opportunities to improve overall health;

Opportunity to visit with a nutritionist;

Enhancing communication between pharmacist, Physician, and Participant (a Physician is able to make more informed decisions about the Participant's medications with the information gathered at the visits with a pharmacist).

(C) Financial Benefits

A Participant may obtain 90-day supply of Tier I (generic) and Tier II (preferred brand name) medications for the price of a 30-day supply Co-pay;

Five (5) $10 coupons are supplied to the Participant to use toward Co-pays of Tier II (preferred brand name) medications;

A Participant's annual out-of-pocket maximums change to become:

$350 per year for Tier II,

$500 per year for Tier III;

Free test strips and lancets are provided up to a limit of 100 per month.

(D) Requirements to Remain Active in the Program.

The Participant must meet one-on-one with a DUR Program pharmacist every 3 to 6 months or as often as deemed necessary by that pharmacist.

ARTICLE 4.0

SCHEDULE OF BENEFITS

4.01 **Coverage Under This Plan.**

Coverage provided under this Plan for Participants shall be in accordance with the provisions as stated in this Plan Document, including any coverage classification stated in the Schedule of Benefits under Section 4.03, hereinbelow.

If coverage classifications are designated on the Schedule of Benefits, any change in the amount of coverage available to a Participant occasioned by a change in the Participant's classification shall become effective automatically on the classification change date provided by the Employer.

4.02 **Participating Pharmacies, Non-Participating Pharmacies.**

(A) Participating Pharmacies

The Plan Sponsor has contracted with selected Pharmacies to serve as preferred Participating Pharmacies. As described in the Schedule of Benefits under Section 4.03, hereinbelow, the amount of benefits payable is higher when a Participant obtains Prescription Drugs and/or Supplies from a Participating Pharmacy rather than a Non-Participating Pharmacy.

Participating Pharmacies can be found on the Claims Administrator's website, **Error! Hyperlink reference not valid.**www.totalscript.com. Participants are referred to that website's directory for a full listing of Participating Pharmacies.

Pharmacies designated as Participating Pharmacies are subject to change from time to time, at the sole discretion of the Plan Sponsor.

(B) Exceptions Where There Is No Access to Participating Pharmacies

(1) In cases where Prescription Drugs and/or Supplies are required and there is no access to Participating Pharmacies, the Plan will allow the following Covered Expenses based on the Participating Pharmacy schedule of benefits:

(a) With respect to Pharmacies located outside the United States of America, the Participant (at his expense) is solely responsible for obtaining an English language translation of

any foreign country Pharmacy claims, invoices, bills, etc. and all medical records pertaining to the Prescription Drugs dispensed or Supplies bought as well as documented proof of the rate of currency exchange;

(2) Participants who:

(a) have dependents that reside beyond the service area of Network Providers; and

(b) are required by court order to provide medical insurance for those dependents,

may obtain coverage through the Plan with benefits consistent with Network Provider benefits provided the Participant receives Prior Authorization for any services or procedures to be performed.

4.03 **Schedule of Benefits.**

- TIER I: 20% Co-pay for generic medication up to $8 per script for up to a 30-day supply (retail) or 90-day supply (mail order).
- TIER II: $25 Co-pay per script for brand name medication up to a 30-day supply (retail) or 90-day supply (mail order).
- TIER III: 20% or $40.00 (whichever is greater) Co-pay with no cap up to a 30-day supply (retail) or 30-day supply (mail order). All new brand name medications introduced to the market will be considered Tier III for a period of 36 months.
- Medications may be subject to change among Tiers during the course of the Plan Year.
- All medications costing in excess of $500 shall be referred to the Claims Administrator for review for Medical Necessity.
- The Plan Administrator retains the right to implement a mandatory step formulary component .
- All brand-name proton pump inhibitors, including Nexium, are not covered.
- Participants will be eligible for a 90-day supply of Tier I & II medication and a yearly $350 annual cap on Tier II brand name medication if they enroll in, and

maintain continuous compliance in, the Lucas County Prescription Drug Use Review Program (see Section 3.03, hereinabove)**.**

- Participants will be eligible for a $500 yearly cap on Tier III medication if they enroll in, and maintain continuous compliance in, the Lucas County Prescription Drug Use Review Program (see Section 3.03, hereinabove). Notwithstanding the foregoing sentence, the prescription medication Enbrel will remain at a straight 20% Co-payment, with no cap unless the Participant's Physician certifies it is being prescribed for treatment of Rheumatoid Arthritis.

- The Plan will pay 100% of the cost of certain over-the-counter ("OTC") medications for Participants with a prescription. These include, but may not necessarily be limited to: Prilosec OTC 20 mg, Prevacid 24 hr., Claritin Syrup, Claritin Tablets, Claritin Reditab, Claritin-D 24 and store brand laratadine D-24 tablets. Participants must have a valid written prescription from their Physician in order to receive this benefit.

For Participants using a Non-Participating Pharmacy, Covered Expenses will be reimbursed at a reduced level. Participants vacationing or traveling outside of the Participating Pharmacy network, must purchase the Prescription Drug or Supply and submit Covered Expenses for reimbursement, minus the applicable deductible or Co-pay. Participants may obtain reimbursement claim forms on the Lucas County Health Benefits website, or in the Health Benefits Department, Suite 440, in the Government Center.

Injectible insulin and oral contraceptives are covered. Disposable syringes and needles are also covered, but only when prescribed with insulin. Insulin and human organ transplant drugs shall be considered generic for purposes of the Plan and are subject to the Tier I Co-pay.

Generic Drug Policy:

If a brand-name Prescription Drug is dispensed when a generic equivalent is available, then the Participant is responsible for the Copay plus any cost differential between the brand name Prescription Drug and the generic.

ARTICLE 5.0

PRESCRIPTION DRUG EXPENSE BENEFITS

5.01 **Benefit Percentage.**

For a Covered Expense incurred by a Participant, the Plan will pay the benefit percentage stated in Section 4.03 hereinabove, however, the Participant, not the Plan, must pay any and all Co-payment and Co-insurance amounts.

5.02 **Allocation and Apportionment of Benefits.**

The Plan Administrator may allocate a Co-payment amount to any Covered Expense and apportion the benefits to the Participant and any assignees. Such allocation and apportionment shall be conclusive and binding upon the Participant and all assignees.

5.03 **Plan Benefit Maximum.**

The total Covered Expense benefits payable for a Participant shall not exceed the Participant's Plan benefit maximum as specified in the Section 4.03, hereinabove, even though the Participant may not have been continuously covered under the Plan.

5.04 **Covered Expenses Must Result From Medically Necessary Treatment by a Physician.**

To be eligible for payment under this Plan, a Covered Expense incurred by a Participant must result from treatment by a Physician and must be Medically Necessary for the diagnosis and treatment of an illness or injury, unless otherwise specifically covered herein.

ARTICLE 6.0

CONTINUATION COVERAGE UNDER COBRA

6.01 **COBRA Definitions.**

For purposes of this Article 6.0 and with respect to any reference to COBRA benefits throughout the Plan document, the following definitions shall apply in addition to those described in Article 1.0, "Definitions".

(A) **"Code".** The Internal Revenue Code of 1986, as amended.

(B) **"Continuation Coverage".** The Plan coverage elected by a Qualified Beneficiary following a Qualifying Event.

(C) **"Covered Employee"**. An individual defined under 42 USC §300bb-8(2).

(D) **"Group Health Plan".** Has the same meaning as that term is defined in COBRA and the regulations thereunder.

(E) **"Qualified Beneficiary".**

(1) An Employee-Participant whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering him/her ineligible for coverage under the Plan;

(2) A Dependent-Participant who becomes eligible for coverage under the Plan due to a Qualifying Event; and/or

(3) A Newborn or newly adopted Child of a Participant who is continuing coverage under COBRA.

(F) **"Qualifying Event".** Any of the following events that may permit a Qualified Beneficiary to elect Continuation Coverage:

(1) termination of the Qualified Beneficiary's employment with his Employer (other than for gross misconduct) or reduction in the Qualified Beneficiary's hours of employment;

(2) the death of a Qualified Beneficiary who was employed by an Employer;

(3) the divorce or Legal Separation of the Qualified Beneficiary;

(4) the Qualified Beneficiary who is an Employee-Participant becoming entitled to Medicare coverage; or

(5) a Child ceasing to be Dependent-Participant.

(G) **"Totally Disabled for Social Security Purposes" or "Total Disability for Social Security Purposes".** A determination made by the Social Security Administration that the Participant is totally and permanently disabled under Title II or Title XVI of the Social Security Act.

6.02 **Right to Elect Continuation Coverage.**

If a Qualified Beneficiary loses coverage under the Plan due to a Qualifying Event, he may elect to continue coverage under the Plan in accordance with COBRA upon payment of the monthly premium specified from time to time by the Plan Administrator. A Qualified Beneficiary must elect the coverage by no later than the sixtieth (60^{th}) day following the later of:

(A) the date of the Qualifying Event triggering the right to elect Continuation Coverage; or

(B) the date the Qualified Beneficiary was notified of his right to elect Continuation Coverage.

6.03 **Notification of Qualifying Event.**

In the event of a Qualifying Event resulting from divorce, Legal Separation or a Dependent Child's ineligibility under the Plan, the Qualified Beneficiary must notify the Employer of the Qualifying Event within sixty (60) days of the Qualifying Event in order for coverage to continue. In addition, a Qualified Beneficiary who is Totally Disabled for Social Security Purposes must notify the Employer in accordance with Section 6.07, below, in order for Plan coverage to continue.

6.04 **Duration of Continuation Coverage.**

(A) The maximum period of time a Qualified Beneficiary may maintain Continuation Coverage for himself (and, if applicable, any Dependent-

Participants) as a result of the Qualified Beneficiary's loss of Plan coverage due to a reduction in hours of employment or termination of employment (other than for gross misconduct) is:

(1) eighteen (18) months from the date of the Qualifying Event; or

(2) (regardless of the date of the Qualifying Event), twenty-nine (29) months from the date of the Qualifying Event if the Qualified Beneficiary is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of the Qualifying Event, PROVIDED the Qualified Beneficiary notifies the Plan Administrator of the Social Security Administration's determination of his Total Disability for Social Security Purposes before the end of the original eighteen (18) month period of Continuation Coverage and no later than sixty (60) days following the date of such determination.

(B) A Qualified Beneficiary (other than an Employee-Participant) who loses coverage due to the Employee-Participant's death, divorce or entitlement to Medicare, and Dependent-Participant who is a Child who has become ineligible for Plan coverage, is eligible for Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event or for such period as prescribed by the Internal Revenue Code, ERISA, and the regulations and administrative pronouncements promulgated thereunder.

6.05 **Termination of Continuation Coverage.**

Continuation Coverage will automatically end earlier than the applicable eighteen (18), twenty-nine (29) or thirty-six (36) month period for a Qualified Beneficiary provided:

(A) the required monthly premium is not received by the Plan Administrator within thirty (30) days following the date it is due;

(B) the Qualified Beneficiary becomes covered under any other group medical insurance plan as an employee or otherwise. If the other group medical insurance plan contains an exclusion or limitation relating to a pre-existing condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for the remaining balance of the Continuation Coverage period specified above under this Plan as long as the exclusion or limitation relating to the pre-existing condition limitation or exclusion applies to the Qualified Beneficiary;

(C) (for a Qualified Beneficiary who is Totally Disabled for Social Security Purposes and continuing coverage for up to twenty nine (29) months) the last day of the month coinciding with or immediately following the thirtieth (30^{th}) day following the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes;

(D) the Qualified Beneficiary becomes entitled to Medicare benefits; or

(E) the Employer ceases to offer any group medical insurance plan.

6.06 **Multiple Qualifying Events.**

If a Qualified Beneficiary maintains Continuation Coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) or twenty-nine (29) months, and a second Qualifying Event occurs during the eighteen (18) or twenty-nine (29) month period, that Qualified Beneficiary may elect, in accordance with Section 6.02 hereinabove, to maintain Continuation Coverage for up to thirty-six (36) months from the date of the first Qualifying Event. In addition, if a Qualified Beneficiary who was an Employee-Participant becomes entitled to benefits under Medicare (whether or not this triggers a Qualifying Event), a Qualified Beneficiary (other than the Employee-Participant) may elect Continuation Coverage for a maximum of thirty-six (36) months from the date of the initial Qualifying Event, to the extent another period of Continuation Coverage is not required by law under COBRA.

6.07 **Total Disability for Social Security Purposes.**

(A) In a case of a Qualified Beneficiary who is determined to be Totally Disabled for Social Security Purposes within sixty (60) days of a Qualifying Event (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependent-Participants who were covered under the Continuation Coverage) for a total of twenty-nine (29) months PROVIDED the Qualified Beneficiary notifies the Plan Administrator:

(1) prior to the end of eighteen (18) months of Continuation Coverage that he was disabled as of the date of the Qualifying Event; and

(2) within sixty (60) days of the determination of Total Disability for Social Security Purposes.

(B) The Plan Administrator will charge the Qualified Beneficiary an increased premium for Continuation Coverage extended beyond eighteen (18) months pursuant to the Section.

(C) If during the period of extended coverage for Total Disability for Social Security Purposes (i.e. Continuation Coverage in excess of eighteen (18) months and less than or equal to twenty-nine (29) months) a Qualified Beneficiary is determined to be no longer Totally Disabled for Social Security Purposes:

(1) The Qualified Beneficiary shall notify the Plan Administrator of this determination within thirty (30) days of the Qualified Beneficiary receiving notice of the determination; and

(2) Continuation Coverage shall terminate the last day of the calendar month that is at least thirty (30) days after the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled for Social Security Purposes.

6.08 **Continuation Coverage.**

The Continuation Coverage elected by a Qualified Beneficiary is subject to all of the terms, conditions, limitations and exclusions which are applicable to the Group Health Plan offered to similarly situated Employee-Participants and Dependent-Participants. The Continuation Coverage is also subject to the rules and regulations under COBRA. If COBRA permits Qualified Beneficiaries to add dependents for Continuation Coverage, such dependents must meet the definition of Eligible Dependent under the Plan.

6.09 **Carryover of Plan Maximums.**

If Continuation Coverage elected by a Qualified Beneficiary, expenses already credited to the Plan's applicable Co-payment features for the Plan Year will be carried forward into the Continuation Coverage.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

6.10 **Payment of Premium.**

(A) The Plan Administrator will determine the amount of premium to be charged for Continuation Coverage for any period. Such premium will be

a reasonable estimate of the cost for providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

(1) The Plan may require a Qualified Beneficiary to pay a premium for coverage that does not exceed 102 percent of the applicable contribution for that period.

(2) For Qualified Beneficiaries whose coverage is continued pursuant to Section 6.07 hereinabove, the Plan may require the Qualified Beneficiary to pay a premium for coverage that does not exceed 150 percent of the applicable premium for Continuation Coverage in excess of eighteen (18) months but less that or equal to twenty-nine (29) months.

(3) Premiums for coverage may, at the election of the payor, be paid in monthly installments.

(B) If Continuation Coverage is elected, the first monthly premium for coverage must be made within forty-five (45) days of the date of election.

(C) Without further notice from the Plan Administrator, the Qualified Beneficiary must pay the monthly premium for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Employer within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the Section 6.05(A) hereinabove.

(D) No claim will be payable under this provision for any period for which the premium for coverage is not timely received from or on behalf of the Qualified Beneficiary.

6.11 **Bankruptcy Under Title XI.**

(A) For purposes of this Section 6.11 only:

(1) "Qualified Beneficiary" means:

(a) An Employee-Participant who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Plan;

(b) An individual who was covered under the Plan as a surviving Spouse of a deceased retiree on the day before the date of the Qualifying Event; and

(c) A Dependent of (a) or (b) above who was covered under the Plan on the day before the date of the Qualifying Event.

(2) "Qualifying Event" means the substantial elimination of coverage under the Plan within one year before or after the Employer files a petition in bankruptcy under Title XI of the United States Code.

(B) If a Qualified Beneficiary experiences a Qualifying Event, he may elect to continue coverage under the Plan if he pays the monthly premium specified from time to time by the Plan Administrator, and makes his election in accordance with Section 6.02, hereinabove.

(C) Continuation Coverage elected under this Section 6.11 will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Employer ceases to offer any group health plans.

SECTION 7.0

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

7.01 **Exclusions from, and Limitations On, Incurred Expenses.**

The following charges and expenses shall not qualify as a Covered Expense:

(A) Charges incurred prior to an Eligible Employee or Eligible Dependent becoming a Participant in the Plan, or after a Participant's coverage is terminated.

(B) Charges incurred by a Participant as a result of war or any act of war, whether declared or undeclared, caused during the Participant's service in the armed forces of any country, involvement in insurrection or civil disobedience, or caused by nuclear explosion or nuclear accident.

(C) Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Participant is entitled to benefits under any worker's compensation or occupational disease law, or any such similar law.

(D) Charges incurred for which the Participant is not legally obligated to pay, or for which a charge would not ordinarily be made in absence of Plan coverage, including but not limited to: Charges incurred to the extent that the Participant is reimbursed, entitled to reimbursement, or in any way indemnified for the expenses by or through any public program.

(E) Charges resulting from an illness or injury arising out of or occurring during the commission of an illegal act by the Participant, including, without limitation, the engaging in an illegal occupation.

(F) Charges incurred for Supplies which constitute personal comfort or Cosmetic items.

(G) Charges incurred in connection with Supplies which are:

(1) not Medically Necessary for the treatment of an injury or illness or for preventative care as specifically provided by this Plan. or

(2) not recommended and approved by a Physician unless specifically shown as a Covered Expense elsewhere in the Plan.

(H) Charges for Supplies or treatment not recognized by the American Medical Association as generally accepted and Medically Necessary for

the diagnosis and/or treatment of an active illness or injury; or charges which are specifically listed by the American Medical Association as having no medical value.

(I) Charges incurred outside the United States if the Participant traveled to such a location for the purpose of obtaining drugs, or Supplies.

.(J) Charges for Experimental/Investigational procedures, drugs, or research studies, or for any Prescription Drugs or Supplies that are not considered legal in the United States whose use is limited to experimental or investigational purposes by laws or regulations under state or federal law.

(K) Charges for completion of claim forms or for preparation of medical reports, referral forms or Prior Authorization forms.

(L) Charges for telephone consultations.

(M) Charges for growth hormone medication.

(N) Third party coverage, such as other primary insurance, workers' compensation, and Medicare will not be duplicated.

(O) Peak flow meters, unless use of a peak flow meter is part of an approved asthma management program.

(P) Vaccination for cholera, plague and yellow fever.

(Q) Charges for any Prescription Drug or Supply not specified in this Plan as a Covered Expense.

(R) Charges for Supplies not covered by Medicare Part B.

(S) Charges for all brand-name proton pump inhibitors.

ARTICLE 8.0

COORDINATION OF BENEFITS

8.01 **Coordination of Benefits.**

This Article 8.0 is intended to prevent the duplication of benefits. It applies when a Participant is also covered by any other prescription drug insurance plan(s) or Other Coverage that has a Prescription Drug benefit. When coverage under more than one plan exists, one plan normally pays its benefits in full and the 'other plan(s)' pay a reduced benefit. The Plan will always pay its portion of Allowable Expenses that, when added to benefits payable by the 'other plan', will not exceed 100% of billed charges or this Plan's Allowable Expenses, whichever is less. Only the amount paid by this Plan will be charged against the Plan benefit maximums.

When this Plan is considered as providing 'secondary' coverage, the benefit payment for each claim submitted by a Participant is calculated by first deducting the amount paid by the 'other plan' (which is providing 'primary' coverage) from expenses determined to be Allowable Expenses under this Plan. The balance is then subject to Co-payments, Benefit Percentage amounts and other provisions as described in Section 4.03, hereinabove.

This Coordination of Benefits provision applies whether or not a claim is filed under the 'other plan'. If the 'other plan' provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

The Plan Administrator and Claims Administrator may release to and obtain from any other insurer, plan or party, any information that it deems necessary for purposes of this Article 8.0. The Participant shall cooperate in obtaining such information and shall furnish all information necessary to implement the provisions of this Article 8.0.

8.01.1 '**Other Plan'.**

For purposes of this Article 8.0 only, the term 'other plan' shall mean any plan, policy or coverage (other than the Plan) providing Prescription Drug and/or Supply benefits or by the reason of health, medical or dental care or treatment.

8.02 **Order of Payment of Claims by Plans.**

With respect to claims submitted that involve the coordination of benefits, the Plan and any 'other plan' shall make claim payments according to the following rules of order, provided Medicare is not involved:

(A) If the 'other plan' contains no provision for the coordination of benefits or states that its coverage is primary, the 'other plan' shall pay a submitted claim before any other plan makes any payment.

(B) If the 'other plan' covers a claimant as an employee (or named insured) that 'other plan' will pay a submitted claim before a plan which covers the claimant as a dependent or as a recipient of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985.

(C) If the 'other plan' covers a claimant as an employee's dependent, that 'other plan' will pay a submitted claim before a plan which covers the claimant as a dependent of a "qualified beneficiary", as that term is defined under the Consolidated Omnibus Budget Reconciliation Act.

(D) Pursuant to rules established by the Ohio Department of Insurance, if the claimant is a dependent child, the plan of the parent whose birthday falls first (omitting year of birth) during the calendar year shall be deemed to provide 'primary' coverage and shall pay on any claims in that capacity. The plan of the other parent shall be deemed to provide 'secondary' coverage and shall pay any claims in that capacity.

Notwithstanding the immediately preceding paragraph, if the child's parents are separated or divorced, then, the plan deemed to provide 'primary' coverage will be determined by the first of the following events to occur:

(1) If a court decree or order makes one parent responsible for the child's health care expenses, that parent's plan is responsible for 'primary' coverage and the other parent's plan is responsible for secondary coverage;

(2) If a court decree or order grants joint custody or 'shared parenting of the child and does not mention health care, then the 'birthday rule' described in the initial paragraph of this Section 8.02(D) applies; or

(3) If neither Section 8.02(D)(1) or (D)(2) above applies, then the order for payment of claims is as follows:

(a) The plan of the parent with custody of the child.

(b) The plan of the spouse of the parent with custody of the child.

(c) The plan of the parent not having custody of the child.

(d) The plan of the spouse of the parent not having custody of the child.

(E) If an 'other plan' does incorporate the rule described in Section 8.02(D), above, but, instead, has a rule based upon the gender of the parent, and if, as a result, the Plan and the 'other plan' do not agree on the order of the benefit payment, the Claims Administrator will determine the order of benefit payments.

(F) A "no fault" automobile policy not described in Section 8.02(A), above, will pay last;

(G) If the order set out in Section 8.02(A), (B), (C), (D), (E), or (F) above does not apply in a particular case, then the plan that has covered the claimant for the longest period of time will pay first.

The Plan Administrator reserves the right to:

(H) obtain information from, or share information with, the 'other plan(s)' regarding Coordination of Benefits without the claimant's consent.

(I) require that the claimant provide information to the Plan Administrator about 'other plans' so that this Article 8.0 may be implemented; and

(J) pay the amount due under the Plan to the 'other plan' if necessary in the Plan Administrator's opinion, in order to satisfy the terms of this Article 8.0.

8.03 **Coordination With Medicare.**

With respect to

(A) Eligible Employees who have Plan coverage by virtue of their current employment status as defined by Medicare; or

(B) Spouses who have Plan coverage by virtue of the Eligible Employee's employment status as defined by Medicare,

who are age sixty-five (65) or older and who are entitled to benefits under Medicare, this Plan will pay 'primary' benefits, unless the Eligible Employee or Spouse refuses coverage under this Plan. If such Eligible Employee or Spouse refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees or Spouses who have enrolled in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives written notification from the Eligible Employee or Spouse stating that the Eligible Employee or Spouse refuses coverage under this Plan. Any charges which are not paid under this Plan shall be submitted to Medicare as a 'secondary' payor.

With respect to

(C) Eligible Employees who have Plan coverage by virtue of their current employment status as defined in Medicare; or

(D) Eligible Dependents who have Plan coverage by virtue of a family member's current employment status as defined in Medicare

who are entitled to benefits under Medicare by reason of receiving Social Security Disability benefits (and who are not or would not be entitled to benefits under Medicare on the basis of 'end stage renal disease'), this Plan will pay 'primary' benefits, unless the Eligible Employee or Eligible Dependent refuses coverage under this Plan. If such Eligible Employee or Eligible Dependent refuses coverage under this Plan, Medicare will be the sole source of benefits. Eligible Employees and/or Eligible Dependents who become Participants in this Plan are deemed to have accepted coverage under this Plan until the Plan Administrator receives written notification from the Eligible Employee or Eligible Dependent stating that the Eligible Employee or Eligible Dependent refuses or waives coverage under this Plan. Any charges, which are not paid under this Plan, should be submitted to Medicare as a 'secondary' payor.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare Part A solely on the basis of 'end stage renal disease' the following will apply:

(E) For items and services furnished on or after August 5, 1997, with respect to Eligible Employees or Eligible Dependents who become entitled to benefits under Part A of Medicare on or after February 5, 1996, the Plan will pay 'primary' benefits during the thirty (30) month period beginning on the earlier of:

(1) The first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or

(2) The first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such thirty (30) month period, Medicare benefits will be 'primary' and this Plan will pay 'secondary' benefits.

(F) Otherwise, the Plan will pay 'primary' benefits during the eighteen (18) month period beginning on the earlier of:

(1) The first month in which the Eligible Employee or Eligible Dependent becomes entitled to benefits under Part A of Medicare; or

(2) The first month in which the Eligible Employee or Eligible Dependent would have been entitled to benefits under Part A of Medicare if such person had filed an application for such benefits. After the expiration of such eighteen (18) month period, Medicare benefits will be 'primary' and this Plan will pay 'secondary' benefits.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare solely on the basis of 'end stage renal disease' and who subsequently become entitled to benefits under Medicare for the reason of attaining age sixty five (65) or for a disability other than 'end stage renal disease', this Plan will pay in accordance with the 'end stage renal disease' provisions stated above.

For those Eligible Employees or Eligible Dependents who are entitled to benefits under Medicare on the basis of attaining age sixty five (65) or because of disability (other than 'end stage renal disease'), and who subsequently become entitled to benefits under Medicare on the basis of 'end stage renal disease', then the 'end stage renal disease' provisions stated above will apply but only if, prior to such entitlement to benefits under Medicare, Medicare was to pay 'secondary' benefits under other provisions of the Plan.

For those Eligible Employees or Eligible Dependents who are not entitled to benefits under Medicare on the basis of attaining sixty five (65) or because of disability (other than 'end stage renal disease') and, simultaneously, 'end stage renal disease', the 'end stage renal disease' provisions stated above will apply. When this Plan's benefits are 'secondary', benefits will be paid as 'secondary' as described under this Article 8.0.

8.04 **Right of Recovery.**

Solely for purposes of this Section 8.04, the term "Participant" will include anyone acting for, or on behalf of, a Participant.

In the event the Plan has a subrogated interest or right of recovery, no Participant shall release any party, person, corporation, entity, insurance policies or funds that may be liable or obligated to that Participant for the acts or omissions of any person or entity, without the written approval of the Plan.

In the event a Participant pursues a claim against a third party or Other Coverage, the Participant agrees to include the Plan's subrogated interest and rights of recovery in that claim, and if there is a failure to do so, the Plan shall be legally presumed to be included in such claim. In the event the Participant does not pursue a claim against a third party or Other Coverage, the Plan shall have the right to pursue, sue, compromise or settle any such claims in the Participant's name and to execute any and all documents necessary to pursue said claims in the Participant's name.

Each Participant hereby agrees to reimburse the Plan, for any past, present and future benefits paid by the Plan, out of any monies recovered from any person, entity, or Other Coverage as a result of judgment, settlement or otherwise, regardless of how those monies are classified. In the event a Participant settles, recovers, or is reimbursed by any third party or Other Coverage, the Participant shall hold any such monies in trust for the benefits of the Plan and shall reimburse the Plan for any benefits so paid hereunder on a first priority basis, regardless of whether or not the Participant has been made whole. If a Participant fails to reimburse the Plan in accordance with this provision the Participant shall be liable to the Plan for any and all expenses (whether in the form of fees or costs) associated with the Plan's attempt to recover such monies from the Participant. Each Participant also agrees to execute and deliver all necessary instruments to furnish such information and assistance, and to take any action the Plan Administrator may require to facilitate enforcement of its rights. The Plan will not pay or be responsible for, without the written consent of the Plan Administrator, any fees or costs associated with a Participant pursuing a claim against a third party or any other coverage.

ARTICLE 9.0

CLAIM PROCEDURES

9.01 **Notice and Proof of Claim.**

Written or electronic notice of a Covered Expense must be given by the Participant or provider to the Claims Administrator, or its designee, on or in a form designated by the Claims Administrator as soon as is administratively feasible, but in no event no later than one (1) year after the date on which the Covered Expense was incurred.

The Claims Administrator or its designee shall approve, partially approve or deny a claim within the time mandated by the Ohio Revised Code. If special circumstances require more time, the Claims Administrator or its designee shall have additional time to complete its review upon notice to the Participant or provider. If a claim is denied (in whole or in part) the Claims Administrator shall provide the Participant or provider with a written notice which will specify the reason(s) for the denial or, if more information about the claim is needed, describe any additional information that may be required to make its decision. This written notice may take the form of an 'explanation of benefits' worksheet or a letter.

9.02 **Appealing a Denial of a Claim or PriorAuthorization**

The Participant or provider whose claim or Prior Authorization has been denied in whole or in part by the Claims Administrator may appeal the denial to the Appeals Committee by written application submitted to the Appeals Committee within sixty (60) days following the date of the denial of the claim or the Prior Authorization by the Claims Administrator. The Participant or provider may review pertinent documents related to the determination and submit issues and comments in writing to the Appeals Committee or its designee.

The Appeals Committee shall make a decision on the appeal within sixty (60) days of the date the written appeal is received by the Appeals Committee unless special circumstances require a sixty (60) day extension of the original sixty (60) day limit, in which case the Participant shall be notified of the extension. Within this period, the Appeals Committee or its designee shall notify the Participant and/or provider of its decision, the reasons for it, and the provisions of the Plan which form the basis of the decision. In conducting its review, the Appeals Committee or its designee may request Documentation from the Participant and/or provider. If the Appeals Committee or its designee fails to make a decision within the time provided, either with respect to the original claim or the appeal, the claim or Prior Authorization is deemed to be denied.

9.03 **Independent Medical Examination.**

The Plan Administrator or its designee shall have the right and opportunity to have the Participant, whose injury or illness is the basis of a claim hereunder, examined by an independent medical examiner of the Plan Administrator's choosing when and as often as it may reasonably require during pendency of a claim. Any such examination and related expenses shall be paid for by the Plan. Each Participant is deemed, through his participation in the Plan, to authorize the Plan Administrator to review the results of the independent medical examination.

9.04 **Legal Proceedings.**

Unless the Participant claiming benefits shall have first exhausted his/her administrative remedies by filing proof of loss and pursuing an appeal under the terms provided in the Plan:

(A) No action at law or in equity shall be brought to recover benefits under the Plan prior to the expiration of a sixty (60) day period (as may be extended by the Plan Administrator) following the filing of proof of loss in accordance with the claim procedures described in this Article 9.0; and

(B) Any action at law or in equity brought to recover benefits under the Plan must be brought within one (1) year from the expiration of the time within which proof of loss is required by the Plan.

9.05 **Payment of Claims.**

When the Claims Administrator receives proof of loss, the Claims Administrator will pay any benefits due. Benefits that provide for periodic payment will be paid for each period, as the Plan becomes liable. The Claims Administrator or its designee will pay benefits to the Participant or provider.

All or a portion of the benefits provided by this Plan may be paid to the institution or person rendering service, unless a Participant directs the Claims Administrator otherwise in writing, and the Plan Administrator consents, prior to the time of filing proof of loss.

The Claims Administrator will not be liable for any payment made in good faith.

9.06 **Overpayments.**

If a Participant receives benefits under the Plan that exceeds those which should have been paid or that should not have been paid at all, the Claims Administrator may:

(A) deduct the excess improper payment from any subsequent benefits payable for the Participant or

(B) recover such amounts by any other appropriate method that the Claims Administrator shall determine.

Each Participant is deemed, through his participation in the Plan, to authorize the foregoing actions in the event of benefit overpayments.

9.07 **Facility of Payment.**

Whenever a Participant or provider to whom payments are directed to be made is determined to be mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Employer nor any fiduciary shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator or his/her designee, or any fiduciary shall not be liable to any person as the result of payment made and shall be fully discharged from all future liability with respect to a payment made.

ARTICLE 10.0

PROTECTED HEALTH INFORMATION (PHI)

10.01 **Use and Disclosure of Protected Health Information (PHI).**

This Plan uses Protected Health Information to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, 'payment' for health care and 'health care operations', as described in Section 10.01.2, hereinbelow.

10.01.1 **"Payment".** For purposes of this Article 10.0, 'payment' includes activities undertaken by the Plan to obtain premiums or 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:

(A) determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and Co-payments as determined for an individual's claim);

(B) coordination of benefits;

(C) adjudication of health benefit claims (including appeals and other payment disputes);

(D) subrogation of health benefit claims;

(E) establishing Employee contributions;

(F) risk adjusting amounts due based on enrollee health status and demographic characteristics;

(G) billing, collection activities and related health care data processing;

(H) claims management and related health care data processing, including auditing payments, investigating and resolving 'payment' disputes and responding to Participant inquiries about 'payments';

(I) obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(J) medical necessity reviews or reviews of appropriateness of care or justification of charges;

(K) utilization review including pre-certification, preauthorization, concurrent review and retrospective review;

(L) disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(M) reimbursement to the Plan.

10.01.2 **Health Care Operations.** For purposes of this Article 10.0, 'health care operations' include, but are not limited to, the following activities:

(A) quality assessment;

(B) 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;

(C) rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(D) underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(E) conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(F) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(G) 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 analyses for policyholders, plan sponsors or other customers;

(3) resolution of internal grievances; and

(4) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" as defined under HIPAA or, following completion of the sale or transfer, will become a covered entity.

10.02 **The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary.**

Provided proper authorization is received or is deemed to be received by the Plan, the Plan will disclose PHI for purposes related to administration of the Plan.

10.03 **Disclosure of PHI to the Plan Sponsor.**

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions:

10.03.1 **Plan Sponsor Agrees to Certain Conditions Regarding PHI.**

The Plan Sponsor agrees:

(A) not to use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(B) to ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(C) not to use or disclose PHI for employment-related actions and decisions unless authorized by the individual who is the subject of the action or decision;

(D) to report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(E) to make PHI available to an individual in accordance with HIPAA's access requirements;

(F) to make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(G) to make available the information required to provide an accounting of disclosures;

(H) to make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the Secretary of the United States Department of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and

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

10.03.2 **Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained.**

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

(A) the Director of the Lucas County Office of Management and Budget;

(B) staff designated by the Director of the Lucas County Office of Management and Budget; and

(C) the designated Lucas County Privacy Officer.

10.03.3 **Limitations of PHI Access and Disclosure**.

The persons described in Section 10.03.2 may only have access to, and use and disclose, PHI for plan administration functions that the Plan Sponsor performs for the Plan.

10.03.4 **Noncompliance Issues.**

The Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions for persons described in Section 10.03.2 who do not comply with the provisions of this Plan document.

ARTICLE 11.0

GENERAL PLAN PROVISIONS

11.01 **Plan Construction.**

This Plan shall be construed in accordance with applicable state and federal law.

Whenever any words are used herein in the masculine, they shall be construed as though they were in the feminine in all cases where they would so apply; and whenever any words herein are used in the singular, they shall be construed as though they were used in the plural in all cases where they would so apply.

11.02 **Plan Administrator Responsibilities.**

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan as it, in its sole discretion, may deem necessary and/or proper. The Plan Administrator's responsibilities include those delegated to the Claims Administrator as set forth in an administration agreement and any addenda thereto.

11.03 **Plan Administrator Discretion.**

The Plan Administrator alone shall be the sole judge of the standards of proof required in any matter hereunder. In the application and interpretation of this Plan document, the decisions of the Plan Administrator shall be final and binding on the Participants, and all other persons and/or entities. The Plan Administrator shall have the full and exclusive power and authority, in its sole discretion, to determine all questions of coverage and eligibility for benefits, methods of providing or arranging for benefits and all other related matters. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all the parties hereto and the beneficiaries thereof.

11.04 **Participant Obligations.**

The coverage provided to a Participant by the Plan shall be at least partially funded by the Employer. If an Employee-Participant elects to enroll an Eligible Dependent in the Plan, the Employee-Participant may be responsible for payment of all or portion of the Eligible Dependent's contributions suitable to cover such

enrollment. The Employer shall deduct such costs on a regular basis from the Employee-Participant's wages or salary.

11.05 **Failure to Enforce.**

Failure of the Plan Sponsor or Plan Administrator or their designate(s) to enforce any provisions of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

11.06 **Statements.**

In the absence of fraud, all statements made by a Participant will be deemed representations and not warranties. No such representation will void the Plan benefits. No such representation may be used in defense of a claim under the Plan unless a copy of the instrument containing such representation is or has been furnished to the Participant.

11.07 **Plan Amendments and Termination.**

The Plan Sponsor establishes this Plan with the intention of maintaining it for an indefinite period of time. However, the Plan Sponsor reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

(A) The Plan Sponsor shall have the right to amend this Plan in whole or in part. Amendments shall be made by a resolution of the Plan Sponsor.

(B) The Plan Sponsor reserves the right at any time to terminate the Plan by a written resolution of the Plan Sponsor.

11.08 **Assignment, Change and Waiver.**

No assignment of a Participant's interest hereunder shall be binding on the Plan Sponsor. The terms of this Plan shall not be waived or changed except as provided in Section 11.07, hereinabove.

11.09 **Plan Is Not A Contract.**

The establishment and maintenance of this Plan shall not be construed as conferring, and does not confer, any legal rights on any Employee to be

continued in the employ of the Employer nor shall this Plan interfere in any way with the right of the Employer to discharge any employee.

This Plan document shall not give Participants any claim, right, action or cause of action against the Plan for acts or omissions of any provider which renders services to Participants. The Plan Administrator does not furnish services but will pay for Covered Expenses incurred for services rendered by providers to Participants.

11.10 **Records.**

By accepting coverage under this Plan, a Participant agrees that all information and records concerning diagnosis and treatment of any condition for which coverage is provided will be available to the Plan Administrator or its designee and its designated Claims Administrator for purposes of determining liability and/or for statistical analysis. Participants are required to furnish specific releases of medical information as necessary for the purposes of determining the Plan's liability.

11.11 **Headings.**

The heading of articles and sections herein are included solely for convenience of reference and shall not affect the meaning of any of the provisions of the Plan.

11.12 **Savings and Severability**

This Plan is intended to be in conformity with all applicable federal, state and local laws and regulations. To the extent any Plan provision is found to be invalid or unenforceable, such provision will be modified to the extent possible to reflect the Plan Sponsor's intentions. All remaining provisions of the Plan will remain in full force and effect unless otherwise determined by the Plan Administrator.

Adopted by Resolution No. _____, this 22nd day of March, 2011.

BOARD OF COUNTY COMMISSIONERS,
LUCAS COUNTY, OHIO

_____
Pete Gerken, President

_____
Tina Skeldon Wozniak, Commissioner

_____
Carol Contrada, Commissioner

APPROVED AS TO FORM:

_____
JULIA R. BATES
LUCAS COUNTY PROSECUTING ATTORNEY
By: Peter N. Kanios