Louisiana HMO Louisiana

**ELIGIBILITY AND TERMINATION AMENDMENT FOR SCHOOL BOARD GROUPS**

This Eligibility and Termination Amendment for School Board Groups ("Amendment") is issued by Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service and Indemnity Company and HMO Louisiana, Inc., a wholly-owned subsidiary of Blue Cross and Blue Shield of Louisiana to the Group and Group Subscriber. This Amendment replaces any previous School Board Eligibility and Termination Amendment and any contradictory provisions in the Benefit Plan. This Amendment is effective on the later of: January 1, 2019, the Group's initial enrollment, or the Group's first renewal on or after January 1, 2019.

All of the provisions, definitions, procedures, conditions, limitations, and exclusions of the Group's Benefit Plan are applicable to this Amendment, unless they conflict with the provisions of this Amendment. If the provisions of the Benefit Plan or other amendment or endorsement heretofore issued conflict with those of this Amendment, the provisions of this Amendment will prevail.

**I**.

The Article entitled "**DEFINITIONS"** is hereby amended and supplemented as follows:

**"Child or Children"** is added and shall read as follows:

Child or Children – includes:

A. the issue of a marriage of the Subscriber;

B. a natural Child of the Subscriber;

C. a legally adopted Child of the Subscriber or a Child in the process of being adopted by the Subscriber;

D. the Child of a male Subscriber, if a court of competent jurisdiction has issued an order of filiation declaring the paternity of the Subscriber for the Child or the Subscriber has formally acknowledged the Child;

E. the issue of a previous marriage or a natural or legally adopted Child of the Subscriber's Spouse, hereinafter "stepchild", which stepchild has not been adopted by the Subscriber and for whom the Subscriber does not have court-ordered legal custody;

F. a grandchild in the court-ordered legal custody of and residing with the grandparent Subscriber, until the end of the month the grandchild attains the age of twenty-six (26);

G. a Dependent for whom the Subscriber has court-ordered legal custody or court-ordered legal guardianship but who is not a Child or grandchild of the Subscriber, until the end of the month the custody or guardianship order expires or the end of the month the Dependent attains the age of eighteen (18), whichever is earlier; or

H. a grandchild of the Employee/Retiree whose parent is covered under the Plan as a Dependent, or a child for whom the Employee/Retiree has current provisional custody, which grandchild/child has not been adopted by the Employee/Retiree and for whom the Employee/Retiree has not obtained court-order legal guardianship/tutorship or court-ordered custody, provided the grandchild/child was enrolled as a Plan Participant and met the eligibility requirements of a "Child" as of December 31, 2015.

**"Code"** is added and shall read as follows:

Code – The Internal Revenue Code of 1986, as amended, and the regulations promulgated thereunder.

**"Date Acquired"** is added and shall read as follows:

Date Acquired – The date a Dependent of a covered Subscriber is acquired in the following instance and on the following dates only:

A. Spouse – the date of marriage;

B. Child or Children

1. Natural Children – the date of birth:

2. Children in the process of being adopted:

a. Agency adoption – the date the adoption contract was executed between the Subscriber and the adoption agency;

b. Private adoption – the date the Act of Voluntary Surrender is executed in favor of the Subscriber. The Group must be furnished with certification by the appropriate clerk of court setting forth the date of execution of the Act and the date the Act became irrevocable, or the date of the first court order granting legal custody, whichever occurs first;

3. Child for whom the Subscriber has legal custody or guardianship – the date of the court order granting legal custody or guardianship;

4. From date of court order of filiation declaring paternity or date of formal acknowledgment of the Child;

5. Stepchild – the date of the marriage of the Subscriber to his Spouse.

**"Dependent"** is deleted and replaced with the following:

Dependent – Any of the following persons who (a) are enrolled for coverage as Dependents by completing appropriate enrollment documents, if they are not also covered as a Subscriber; and, (b) whose relationship to the Subscriber has been Documented, as defined herein:

A. The covered Subscriber's Spouse;

B. A Child or Children from Date Acquired until end of month of attainment of age twenty-six (26); except for the following:

1. A grandchild or Dependent of a Dependent of the Subscriber whose parent is covered under the Plan as a Dependent and for whom the Subscriber has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which grandchild or dependent of a Dependent was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until end of month the parent Dependent Child is no longer enrolled on or eligible to participate in the Plan, the end of the month the grandchild or Dependent of a Dependent

turns twenty-six (26), or the grandchild or Dependent of a Dependent no longer meets the eligibility requirements under this Plan, whichever is earlier;

2. A child for whom the Subscriber has current provisional custody and for whom the Subscriber has not obtained court-ordered legal guardianship/tutorship or court-ordered custody and has not adopted, which child was covered under the Plan and met the definition of a "Child" as of December 31, 2015, from Date Acquired until the end of the month of the 2016 anniversary date of the existing provisional custody document, the end of the month the child reaches the age of eighteen (18), or December 31, 2016, whichever is earlier;

3. A Child, who is not the Child or grandchild of the Subscriber, for whom the Subscriber has court-ordered custody or court-ordered legal guardianship but who has not been adopted by the Subscriber, from Date Acquired until the end of the month the custody/guardianship order expires or the end of the month the Child reaches the age of eighteen (18), whichever is earlier.

4. A stepchild of the Subscriber, which stepchild has not been adopted by the Subscriber and for whom the Subscriber does not have court-ordered legal custody, until the earliest of:

   a. The end of the month the Subscriber is no longer married to the stepchild's parent;

   b. The end of the month of the death of the Subscriber 's Spouse who is the stepchild's parent; or

   c. The end of the month the stepchild attains the age of twenty-six (26).

C. A Child or Children of any age who meets the criteria set forth in the Eligibility Article of this Benefit Plan.

**"Documented"** is added and shall read as follows:

Documented (with respect to a Dependent of a Subscriber) – the following written proof of relationship to the Subscriber has been presented for inspection and copying to the Group:

A. The covered Subscriber's Spouse: Certified copy of certificate of marriage indicating date and place of marriage;

B. Child:

1. Natural or legally adopted Child of Subscriber – Certified copy of birth certificate listing the Subscriber as parent or certified copy of legal acknowledgment of paternity signed by the Subscriber, certified copy of court order of filiation declaring paternity of the Subscriber or certified copy of adoption decree naming the Subscriber as adoptive parent;

2. Stepchild – Certified copy of certificate of marriage to Spouse and birth certificate listing Spouse as natural or adoptive parent;

3. Child placed with Subscriber for adoption by agency adoption or irrevocable act of surrender for private adoption – Certified copy of adoption placement order showing date of placement or copy of signed and dated irrevocable act of surrender;

4. Child for whom Subscriber has been granted guardianship or legal custody, including provisional custody – Certified copy of the signed court order granting legal guardianship or custody, or the original notarized act granting provisional custody in proper statutory form and substance;

C. Medical Child Support Order – Child eligible for coverage under this Benefit Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). A QMCSO is a state court order or judgment, including approval of a settlement agreement that:

1. Provides for support of a covered Subscriber's Dependent Child;

2. Provides for health care coverage for that Dependent Child;

3. Is made under state domestic relations law (including a community property law);

4. Relates to Benefits under the Benefit Plan; and

5. Is "qualified" in that it meets the technical requirements of applicable state law.

QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical Child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993). An NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Benefit Plan for the Dependent Child of a non-custodial parent who is (or will become) a Subscriber by a domestic relations order that provides for healthcare coverage. Procedures for determining the qualified status of medical Child support orders are available at no cost upon request from the Group.

D. Child age twenty-six (26) or older who is incapable of self-sustaining employment by reason of physical or mental disability who was covered prior to age twenty-six (26). No earlier than six (6) months prior to attaining age twenty-six (26) – documentation as described in B.1. through B.4. above, together with an application for continued coverage must be filed with the Group on a form designated by the Group.

1. This application must be accompanied by an attestation from the Dependent Child's attending Physician setting forth the specific physical or mental disability and certifying that the Child is incapable of self-sustaining employment by reason of that disability. The Group may require additional medical or other supporting documentation regarding the disability to process the application.

2. After the initial approval, the Group may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

E. Such other written proof of relationship to the Subscriber deemed sufficient by the Group.

**"Employee"** is added and shall read as follows:

Employee - A full-time Employee as defined by Group and in accordance with state law, and any Full-Time Equivalent. The Employee is the Subscriber on this Benefit Plan.

**"Full-Time Equivalent (FTE)"** is added and shall read as follows:

Full Time Equivalent (FTE) – A full-time equivalent Employee who is employed on average 30 or more hours per week, as defined under Code section 4980H and determined pursuant to the regulations issued thereunder.

**"HIPAA"** is added and shall read as follows:

HIPAA **–** The Health Insurance Portability and Accountability Act of 1996 (U.S. Public Law 104-191) and Federal Regulations promulgated pursuant thereto.

**"Retiree"** is added and shall read as follows:

Retiree – An individual who was a covered Employee immediately prior to the date of retirement and who, upon retirement, satisfied one of the following categories:

A. Immediately received retirement benefits from an approved state or state governmental agency defined benefit plan; or

B. Was not eligible for participation in such ~~a~~ plan or who had legally opted not to participate in such plan, and either:

1. began employment prior to September 15, 1979, has ten (10) years of continuous state service and has reached the age of sixty-five (65); or

2. began employment after September 16, 1979, has ten (10) years of continuous state service and has reached the age of seventy (70); or

3. began employment after July 8, 1992, has ten (10) years of continuous state service, ~~had~~ has a credit for a minimum of forty (40) quarters in the Social Security system at the time of employment~~,~~ and has reached the age of sixty-five (65); or

4. maintained continuous coverage with the employer as an eligible Dependent until he became eligible to receive a retirement benefit from an approved state governmental agency defined benefit plan as a former state Employee.

C. Immediately received retirement benefits from a state-approved or state governmental agency-approved defined contribution plan and has accumulated the total number of years of creditable service which would have entitled him to receive a retirement allowance from the defined benefit plan of the retirement system for which the Employee would have otherwise been eligible. The appropriate state governmental agency or retirement system responsible for administration of the defined contribution plan shall be responsible for certification of eligibility hereunder to the Company.

D. Retiree also means an individual who was a covered Employee who continued the coverage through the provisions of COBRA immediately prior to the date of retirement and who, upon retirement, qualified for any items A., B., or C. above.

**"Temporary Employee"** is added and shall read as follows:

Temporary Employee – An Employee who is employed for 120 consecutive, calendar days or less.

**II.**

The Article entitled **"SCHEDULE OF ELIGIBILITY"** is hereby deleted and replaced with the following:

**ANY ELIGIBILITY REQUIREMENT LISTED IN THIS BENEFIT PLAN, WHICH IS NOT MANDATED BY STATE OR FEDERAL LAW, MAY BE DELETED OR REVISED ON THE SCHEDULE OF BENEFITS.**

NOTE: A Temporary Employee does not meet the Eligibility Requirements under this Benefit Plan, unless such Temporary Employee is determined to be an FTE.

A. Persons to be Covered

1. Employee

a. A full-time Employee as defined by the employer and any FTE, both as determined in accordance with applicable state and federal law.

b. Husband and Wife, Both Employees – NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THIS BENEFIT PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE. If a covered Spouse is eligible for coverage as an Employee and chooses to be covered separately at a later date, that person will be a covered Employee effective the first day of the month after the election of separate coverage. The change in coverage will not increase Benefits.

c. Effective Dates of Coverage, New Employee, Transferring Employee, and FTE

Coverage for each Employee who completes the applicable enrollment form and agrees to make the required payroll contributions to his employer is effective as follows:

(1) If employment begins on the first day of the month, coverage is effective on the first day of the following month (for example, if hired on July 1st, coverage will begin on August 1st).

(2) If employment begins on or after the second day of the month, coverage is effective on the first day of the second month following employment (for example, if hired on July 15th, coverage will begin on September 1st).

(3) Employee coverage will not become effective unless the Employee completes an enrollment form within thirty (30) days following the date of employment. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next open enrollment period or Special Enrollment period.

(4) An Employee, who transfers employment from another state entity, school board or state political subdivision, must complete a transfer form within thirty (30) days following the date of transfer to maintain coverage without interruption. If the Employee does not timely complete an enrollment form, the Employee will have to wait to enroll until the next open enrollment period or Special Enrollment period.

(5) An Employee who is determined to be an FTE shall be allowed to enroll in this Benefit Plan with coverage effective as required under Code Section 4980H, which is the first day of the Plan Year for those Employees determined to be FTEs during the standard determination period and which is no later than the thirteenth month of employment for those Employees determined to be FTEs during their initial measurement period.

d. Re-Enrollment for Health and/or Life Benefits

(1) Full-time Employees returning to full time or part-time status with less than thirteen (13) weeks (less than 26 weeks for educational institutions) since separation or termination may resume coverage if application is made within thirty (30) days following return to work. Coverage will resume on the first of the month following return to work.

(2) If an Employee acquires an additional Dependent during the termination period, that Dependent may be covered if added within thirty (30) days of re-employment.

e. Board Members

School board members, defined by the employer as full-time Employees, are eligible to participate in this Benefit Plan.

**2.** Retiree Coverage Eligibility

a. Retirees of employer are eligible for Retiree coverage under this Benefit Plan.

b. Retirees of employer may not be covered as an Employee.

c. Effective Date of Coverage - Retiree coverage will be effective on the first day of the month following the date of retirement, if the Retiree and Participant Employer have agreed to make and are making the required contributions. For purposes of eligibility, the date of retirement shall be the date the person is eligible to receive a retirement plan distribution. For example, if date of retirement is July 15, retiree coverage will begin August 1; if date of retirement is August 1, retiree coverage will begin September 1.

**3.** Documented Dependent Coverage – Eligibility

a. Documented Dependent of an eligible Subscriber will be eligible for Dependent coverage on the latest of the following dates:

(1) The date the Employee becomes eligible;

(2) The date the Retiree becomes eligible; or

(3) The Date Acquired for Employee/Retiree's Dependent.

b. Effective Dates of Coverage – Application for coverage must be made within thirty (30) days of eligibility for coverage.

(1) Documented Dependents of Employees – Coverage will be effective on the Date Acquired.

(2) Documented Dependents of Retirees – Coverage will be effective on the first day of the month following the date of retirement if the Retiree and his Dependents were covered immediately prior to retirement. Coverage for Dependents of Retirees first becoming eligible for Dependent coverage following the date of retirement will be effective on the Date Acquired.

c. NO ONE MAY BE ENROLLED SIMULTANEOUSLY AS AN EMPLOYEE AND AS A DEPENDENT UNDER THE PLAN, NOR MAY A DEPENDENT BE COVERED BY MORE THAN ONE EMPLOYEE.

**4.** HIPAA Special Enrollment Events

Certain eligible persons may enroll in the Plan if they experience a HIPAA Special Enrollment Event as provided by federal law. HIPAA Special Enrollment Events include but are not limited to birth, adoption, placement for adoption, marriage, eligibility for premium assistance subsidy under Medicaid or State Children's Health Insurance Program (SCHIP) coverage, loss of other health coverage through divorce, legal separation, or annulment, and loss of eligibility based on termination of Medicaid or SCHIP coverage. Application to the Plan Administrator must be made within thirty (30) days of the HIPAA special enrollment event unless a longer period is provided by federal law or by OGB.

**5.** Other Special Enrollment or Disenrollment Events

Employees/Retirees may also change coverage outside of Annual Enrollment if they or an applicable eligible dependent experience an OGB Plan-Recognized Qualified Life Event that allows for a specific change in coverage and make timely application to the Plan Administrator for such. The OGB Plan-Recognized Qualified Life Events are subject to change at any time and can be found at **http://info.groupbenefits.org/qle/**.

**6.** Medicare Advantage Option for Retirees other than Group-Sponsored Plans

Retirees who are eligible to participate in a Medicare Advantage plan who cancel coverage with the Benefit Plan upon enrollment in a Medicare Advantage plan may re-enroll in the Benefit Plan upon withdrawal from or termination of coverage in the Medicare Advantage plan, during the next annual Enrollment, for coverage effective at the beginning of the next Plan year.

Retirees who elect to participate in a Medicare Advantage plan not sponsored by Employer will not be allowed to reenroll in a plan offered by Employer upon withdrawal from or termination of coverage from the Medicare Advantage plan.

**7.** TRICARE for Life Option for Military Retirees

Retirees eligible to participate in the TRICARE for Life (TFL) option on and after October 1, 2001, who cancel coverage with the Benefit Plan upon enrollment in TFL may re-enroll in the Benefit Plan in the event that the TFL option is discontinued or its benefits significantly reduced.

B. Change of Classification

1. Adding or Deleting Dependents

When a Dependent is added to the Employee's/Retiree's coverage as a result of a HIPAA Special Enrollment Event or deleted from the Employee's/Retiree's coverage consistent with a change in the Dependent's status, application made by an active Employee shall be provided to the Employee's Human Resources liaison, and application made by a Retiree shall be provided to OGB. Application is required to be made within thirty (30) days of the HIPAA Special Enrollment Event or change in status unless otherwise specified in this Plan document or unless a longer application period is required by federal or state law. When a Dependent is added to or deleted from coverage during an OGB-designated enrollment period, application is required to be made as directed by OGB for the designated enrollment period.

2. Change in Coverage

When the addition of a Dependent as a result of a HIPAA Special Enrollment Event results in a change in classification, the change in classification will be effective on the date of the HIPAA Special Enrollment Event.

3. Notification of Change

It is the Employee's/Retiree's responsibility to make application for any change in classification of coverage amount.

**III.**

The Article entitled **"CONTINUATION OF COVERAGE RIGHTS"** is hereby deleted and replaced with the following:

**A. Leave of Absence**

1. Leave of Absence without Pay, Employer Contributions to Premiums

a. A participating Employee who is granted leave of absence without pay due to a service related injury may continue coverage and the employer shall continue to pay its portion of health plan premiums for up to twelve (12) months if the Employee continues his coverage. Failure of Employee to pay his premium will result in cancellation of coverage.

b. A participating Employee who suffers a service related injury that meets the definition of a total and permanent disability under the worker's compensation laws of Louisiana may continue coverage and the employer shall continue to pay its portion of the premium until the Employee becomes gainfully employed or is placed on state disability retirement.

c. A participating Employee who is granted leave of absence without pay in accordance with the federal Family and Medical Leave Act (FMLA) may continue coverage during the time of such leave and the employer shall continue to pay its portion of premiums if the Employee continues his coverage. Failure of Employee to pay his premium will result in cancellation of coverage.

2. Leave of Absence Without Pay – No Employer Contributions to Premiums

   An Employee granted leave of absence without pay for reasons other than those stated in above in paragraphs 1. a-c, may continue to participate in the Benefit Plan for a period up to twelve (12) months upon the Employee's payment of the full premiums due.

**B. Disability**

1. Employees who have been granted a waiver of premium for Basic or Supplemental Life Insurance prior to July 1, 1984, may continue health coverage for the duration of the waiver if the Employee pays the total contribution to the Participant Employer. Disability waivers were discontinued effective July 1, 1984.

2. If a Participant Employer withdraws from the Plan, health and life coverage for all Covered Persons will terminate on the effective date of withdrawal.

**C. Surviving Dependents/Spouse**

1. Benefits under this Benefit Plan for covered Dependents of a deceased covered Employee or Retiree will terminate on the last day of the month in which the Subscriber's death occurred unless the surviving covered Dependents elect to continue coverage.

   a. The surviving Spouse of a Subscriber may continue coverage unless or until the surviving Spouse is or becomes eligible for coverage in a group health plan other than Medicare.

   b. The surviving Dependent Child of a Subscriber may continue coverage unless or until such Dependent Child is or becomes eligible for coverage under a group health plan other than Medicare or until attainment of the termination age for Children, whichever occurs first.

   c. Surviving Dependents will be entitled to receive the same employer premium contributions as Employees and Retirees, subject to the provisions of La. R.S. 42:851 and rules promulgated pursuant thereto by the Office of Group Benefits.

   d. Coverage provided by the Civilian Health and Medical Program for the Uniform Services (CHAMPUS/TRICARE) or successor will not be sufficient to terminate the coverage of an otherwise eligible surviving Spouse or a Dependent Child.

   e. A surviving Spouse or Dependent cannot add new Dependents to continued coverage other than a Child of the deceased Subscriber born after the Subscriber's death.

2. Employer/Dependent Responsibilities

   a. It is the responsibility of the surviving covered Dependent to notify the Group within thirty (30) days of the death of the Employee or Retiree.

   b. The Group will notify the surviving Dependents of their right to continue coverage.

   c. Application for continued coverage must be made in writing to the Group within sixty (60) days of receipt of notification, and premium payment must be made within forty-five (45) days of the date continued coverage is elected for coverage retroactive to the date coverage would have otherwise terminated.

3. Coverage for the surviving Spouse under this section will continue until the earliest of the following:

   a. Failure to pay the applicable premiums, contributions and surcharges timely.

b. Eligibility of the surviving Spouse under a group health plan other than Medicare.

4. Coverage for a surviving Dependent Child under this section will continue until the earliest of the following events:

   a. Failure to pay the applicable premiums, contributions and surcharges timely.

   b. Eligibility of the surviving Dependent Child for coverage under any group health plan other than Medicare; or

   c. The end of the month of the attainment of the termination age for that specific Child.

   d. The provisions of B.1. through B.4. above are applicable to surviving Dependents who on or after July 1, 1999, elect to continue coverage following the death of an Employee or Retiree. Continued coverage for surviving Dependents that made such election before July 1, 1999, shall be governed by the rules in effect at the time of the election.

**D. Over-Age Dependents**

1. If a Dependent Child is incapable (and became incapable prior to attainment of age twenty-six (26)) of self-sustaining employment, by reason of physical or mental disability, the coverage for the Dependent Child may be continued for the duration of incapacity.

   a. No earlier than six (6) months prior to the Dependent Child reaching age twenty-six (26), an application for continued coverage must be filed with the Plan Administrator on a form designated by the Group, with current medical information from the Dependent Child's attending Physician, must be submitted to the Company to establish eligibility for continued coverage as set forth above.

   b. After the initial approval, the Group may require the submission of additional medical or other supporting documentation substantiating the continuance of the disability, but not more frequently than annually, as a precondition to continued coverage.

**E. Military Leave**

Members of the National Guard or of the United States military reserves who are called to active military duty and their covered Dependents will have access to continued coverage under this Benefit Plan.

When called to active military duty, Subscribers and their covered Dependents may:

1. Continue participation in this Benefit Plan during the period of active military service, in which case the employer may continue to pay its portion of premiums; or

2. Cancel participation in this Benefit Plan during the period of active military service, in which case such Subscribers may apply for reinstatement of coverage within thirty (30) days of:

   a. the date of the Employee's re-employment with the employer;

   b. the Dependent's date of discharge from active military duty; or

   c. the date of termination of extended health coverage provided as a benefit of active military duty, such as TRICARE Reserve Select. For Subscribers who elect this option and timely apply for reinstatement of coverage, the lapse in coverage during active military duty or extended military coverage will not result in any adverse consequences with respect to the participation schedule set forth in La. R.S. 42:851E and the corresponding rules promulgated by the Office of Group Benefits.

## F. COBRA

1. Employees

   a. Coverage under this Benefit Plan for a covered Employee will terminate on the last day of the calendar month during which employment is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or coverage under a Leave of Absence expires unless the covered Employee elects to continue coverage at the Employee's own expense. Employees terminated for gross misconduct are not eligible for COBRA coverage.

   b. The Participant Employer shall notify the Plan Administrator within thirty (30) days of the date coverage would have terminated because of any of the foregoing events. OGB's third-party COBRA vendor ("COBRA Administrator") will notify the Employee within fourteen (14) days of receipt of this notification of his right to continue coverage.

   c. Application for continued coverage must be made in writing to the Group within sixty (60) days of the date of the election notification, and premium payment must be made within forty-five (45) days of the date the Employee elects continued coverage. Coverage will be retroactive to the date it would have otherwise terminated.

   d. Coverage under this section will continue until the earliest of the following:

      (1) Failure to pay the applicable premiums, contributions and surcharges timely;

      (2) Eighteen (18) months from the date coverage would have otherwise terminated;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

      (5) The employer ceases to provide any group health plan for its Employees or Retirees.

   e. If employment for a covered Employee is terminated (voluntarily or involuntarily) or significantly reduced, the Employee no longer meets the definition of an Employee, or Leave of Absence has expired, and the Employee has not elected to continue coverage, the covered Spouse and/or covered Dependent Children may elect to continue coverage at his own expense. The elected coverage will be subject to the above stated notification and termination provisions.

2. Surviving Dependents

   a. Coverage under this Benefit Plan for covered surviving Dependents of a Subscriber will terminate on the last day of the month in which the Subscriber's death occurs, unless the surviving covered Dependents elect to continue coverage at their own expense.

   b. It is the responsibility of Employer and/or surviving covered Dependents to notify the Group within thirty (30) days of the death of the Subscriber. The Group will notify the surviving Dependents of their right to continue coverage. Application for continued coverage must be made in writing to the Group within sixty (60) days of the date of the election notification.

   c. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date the continued coverage was elected, retroactive to the date coverage would have terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the surviving Dependents under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The employer ceases to provide any group health plan for its Employees or Retirees.

3. Ex-Spouse/Ex-Stepchildren – Divorce, Annulment, Legal Separation or Death

a. Coverage under this Benefit Plan for a Subscriber's Spouse (and any Stepchildren enrolled on the plan) will terminate on the last day of the month during which dissolution of the marriage occurs by virtue of a legal decree of divorce, annulment or legal separation from the Subscriber, unless the covered ex-Spouse elects to continue coverage at his own expense.

b. Coverage under this Plan for a Subscriber's stepchild will terminate on the last day of the month of the death of the Subscriber's Spouse who is the stepchild's parent.

c. It is the responsibility of the Subscriber or the ex-Spouse/ex-Stepchild to notify the Group of the divorce, annulment, legal separation or death within sixty (60) days from the date of the divorce, annulment, legal separation or death. The Group will notify the ex-Spouse and ex-Stepchildren covered on the plan within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Group within sixty (60) days of the election notification.

d. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage for the ex-Spouse (and ex-Stepchildren covered on the plan) under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The employer ceases to provide any group health plan for its Employees or Retirees.

4. Dependent Children

a. Coverage under this Benefit Plan for a covered Dependent Child will terminate on the last day of the month during which the Dependent Child no longer meets the definition of an eligible covered Dependent, unless the Dependent Child elects to continue coverage at his own expense.

b. It is the responsibility of the Dependent Child to notify the Group of his election to continue coverage within sixty (60) days of the date coverage would have terminated. The Group will notify the Dependent Child within fourteen (14) days of his right to continue coverage. Application for continued coverage must be made in writing to the Group within sixty (60) days of receipt of the election notification.

c. Payment of premiums, contributions and surcharges must be made within forty-five (45) days of the date the continued coverage is elected, for coverage retroactive to the date coverage would have otherwise terminated. After the first payment for COBRA coverage, monthly payments for each subsequent month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for a Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The employer ceases to provide any group health plan for its Employees or Retirees.

5. Dependents of COBRA Participants

a. If a covered terminated Employee has elected to continue coverage and if during the period of continued coverage the covered Spouse or a covered Dependent Child becomes ineligible for coverage due to:

(1) Death of the Employee,

(2) Divorce, Annulment, or Legal Separation from the Employee, or

(3) A Dependent Child no longer meets the definition of an eligible covered Dependent, then, the Spouse and/or Dependent Child may elect to continue COBRA coverage at his own expense. Coverage will not be continued beyond thirty-six (36) months from the date coverage would have otherwise terminated.

b. It is the responsibility of the Spouse and/or the Dependent Child to notify the Group within sixty (60) days of the date COBRA coverage would have terminated.

c. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

d. Coverage for the Spouse or Dependent Child under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Thirty-six (36) months beyond the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan; or

(5) The employer ceases to provide any group health plan for its Employees or Retirees.

6. Disability COBRA

a. If a Member is determined by the Social Security Administration or by the Group (in the case of a person who is ineligible for Social Security Disability benefits due to insufficient quarters of employment) to have been totally disabled on the date the Member became eligible for continued coverage or within the initial eighteen (18) months of continued coverage, coverage under this Benefit Plan may be extended at his own expense up to a maximum of twenty-nine (29) months from the date coverage would have otherwise terminated.

b. To qualify for disability COBRA, the Member must:

(1) Submit a copy of his Social Security Administration's disability determination to the Group before the initial eighteen (18) month continued coverage period expires and within sixty (60) days after the latest of:

(a) The date of issuance of the Social Security Administration's disability determination; and

(b) The date on which the qualified beneficiary loses (or would lose) coverage under terms of the Benefit Plan as a result of the covered Employee's termination or reduction of hours.

(2) In the case of a person who is ineligible for Social Security disability benefits due to insufficient quarters of employment, submit proof of total disability to the Group before the initial eighteen (18) month continued coverage period expires. The Group will make the determination of total disability based upon medical evidence, not conclusions, presented by the applicant's physicians, work history and other relevant evidence presented by the applicant.

c. For purposes of eligibility for extended continued coverage under this section, total disability means the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last for a continuous period of twelve (12) months. To meet this definition one must have a severe impairment which makes one unable to do his previous work or any other substantial gainful activity which exists in the national economy, based upon a person's residual functional capacity, age, education, and work experience.

d. Monthly payments for each month of extended disability COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

e. Coverage under this section will continue until the earliest of the following:

(1) Failure to pay the applicable premiums, contributions and surcharges timely;

(2) Twenty-nine (29) months from the date coverage would have otherwise terminated;

(3) Entitlement to Medicare;

(4) Coverage under a group health plan;

(5) The employer ceases to provide any group health plan for its Employees or Retirees; or

(6) Thirty (30) days after the month in which the Social Security Administration determines that the Member is no longer disabled. (The Member must report the determination to the Group within thirty (30) days after the date of issuance by the Social Security Administration.) In the case of a

person who is ineligible for Social Security disability benefits due to insufficient quarters of an employment, thirty (30) days after the month in which the Group determines that the Member is no longer disabled.

7. Medicare COBRA

   a. If an Employee becomes entitled to Medicare less than eighteen (18) months before the date the Employee's eligibility for Benefits under this Benefit Plan terminates, the period of continued coverage available for the Employee's covered Dependents will continue until the earliest of the following:

      (1) Failure to pay the applicable premiums, contributions and surcharges timely;

      (2) Thirty-six (36) months from the date of the Employee's Medicare entitlement;

      (3) Entitlement to Medicare;

      (4) Coverage under a group health plan; or

      (5) The employer ceases to provide any group health plan for its Employees or Retirees.

   b. Monthly payments for each month of COBRA coverage are due on the first day of the month for that month's COBRA coverage. A grace period of thirty (30) days after the first day of the month will be provided for each monthly payment.

8. Miscellaneous Provisions

   During the period of continuation of coverage, Benefits will be identical to those provided to others enrolled in this Benefit Plan under its standard eligibility provisions for Employees, Retirees and their Dependents.

**IV.**

The Article entitled "**GENERAL PROVISIONS – GROUP/POLICYHOLDER AND MEMBERS"** is hereby amended to add the following section:

**Retroactive Cancellation of Coverage**

1. The Group may retroactively cancel coverage in the following instances:

   a. To the extent the cancellation of coverage is attributable to a failure of the Subscriber to timely pay required premiums, contributions and surcharges toward the cost of coverage; or

   b. The cancellation of coverage is initiated by the Subscriber.

2. When the Group retroactively cancels coverage, the Subscriber shall be liable to the Group for all benefits paid on behalf of the Subscriber and/or Dependents of the Subscriber after the effective date of rescission or cancellation of coverage.

**V.**

The section entitled "**Termination of a Member's Coverage"** is hereby deleted and replaced with the following:

Subject to continuation of coverage and COBRA rules, all Benefits of a Member will terminate under this Benefit Plan on the earliest of the following dates:

1. The date the Benefit Plan terminates;
2. The date contribution is due if the Group fails to pay the required contribution;
3. The date contribution is due if the Member fails to make any contribution which is required for the continuation of coverage;
4. The last day of the month of the covered Subscriber's death;
5. The last day of the month in which the Member ceases to be eligible.

**All other provisions remain unchanged.**

I. Steven Udvarhelyi, M. D.
President and Chief Executive Officer